THE

Chicago Medical Journal

AND

EXAMINER.

VOL. XXXVIII.—JANUARY, 1879.—No. 1.

To our Readers and Correspondents.

Beginning with Vol. XXXVII., July, 1878, the CHICAGO MEDICAL JOURNAL AND EXAMINER prints all records of length and weight in terms of the Metric System, and all records of temperature in degrees of the Centigrade Scale. The Metric System, legalized in the United States and Great Britain, is extensively or exclusively employed by other civilized nations, and has thus become an essential part of the international language of science. It is recommended for adoption to the profession in this country by the American Medical Association and other scientific bodies. To-day no physician can afford to be ignorant of its value, its simplicity and the meaning of its terms.

The subjoined tables and scales, which have been kindly prepared for us by Prof. W. S. Haines, will be continuously reproduced in subsequent numbers of this journal, for the ready reference of our readers and correspondents.

METRIC MEASURES OF LENGTH.

Millimeter	0.001 of a Meter	0.03937	inches.
Centimeter	0.01 " "	0.39370	"
Decimeter	0.1 " "	3.93707	"
Meter	**1.**	**Meter**	**39.37079** "
Decameter	10.	Meters	393.70790 "
Hectometer	100.	"	3937.07900 "
Kilometer	1000.	"	39370.79000 "

METRICAL WEIGHTS.

Milligram	0.001 of a Gram	0.015	grains.
Centigram	0.01 " "	0.154	"
Decigram	0.1 " "	1.543	"
Gram	**1.**	**Gram**	**15.432** "
Decagram	10.	Grams	154.323 "
Hectogram	100.	"	1543.234 "
Kilogram	1000.	"	15434.348 "

☞ The United States "nickel" five cent piece weighs five grams, and is two centimeters in diameter.

APPROXIMATE EQUIVALENT OF METRICAL WEIGHTS.

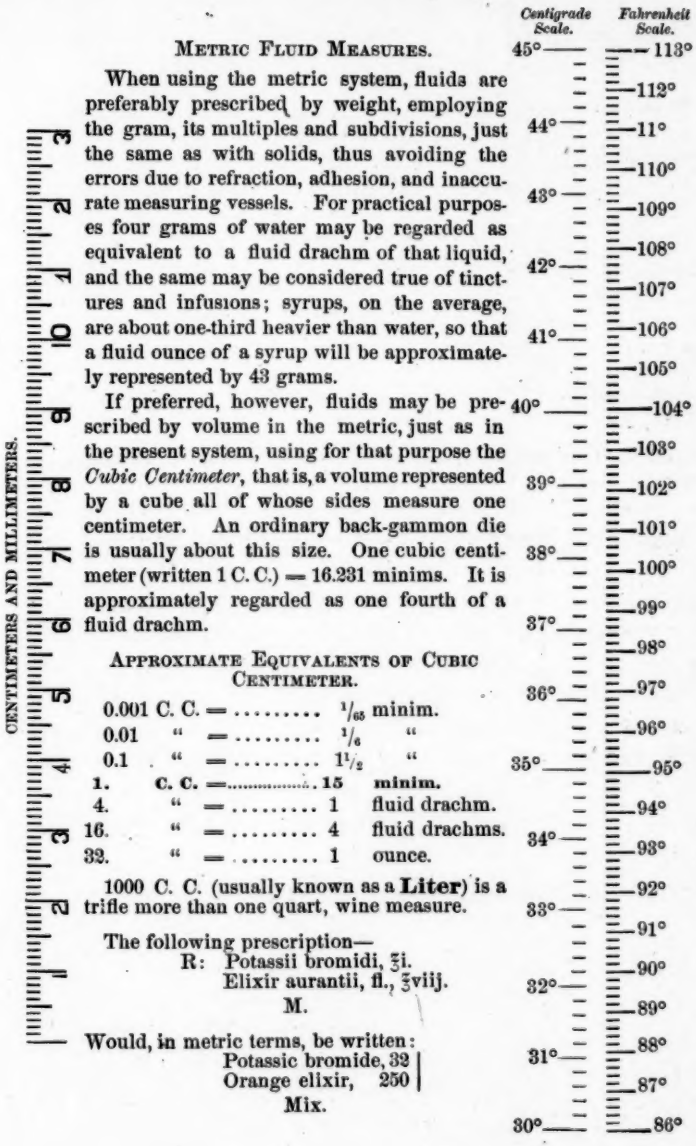
For Rapid Reference.

Milligrams.	*Grains.*	*Decigrams.*	*Grains.*
1 (written 0.001 or |001)*.	1/65	1 (written 0.1 or |1)	1 1/2
2	1/32	2	3
3		3	4 1/2
4	1/16	4	6
5	1/13	5	7 1/2
6	1/11	6	9
7	1/9	7	11
8	1/8	8	12 1/2
9	1/7	9	14

Centigrams.	*Grains.*	*Grams.*	*Grains.*
1 (written 0.01 or |01)	1/6	1 (written 1. or 1|)	15
2	1/3	2	30
3	6/13	3	46
4	7/11	4	61
5	3/4	5	77
6	9/10	6	92
7	1	7	108
8	1 1/4	8	123
9	1 1/3	9	139

A Kilogram—2 1/5 lbs. Avoirdupois.

* The decimal *line* instead of points makes errors impossible.



METRIC FLUID MEASURES.

When using the metric system, fluids are preferably prescribed by weight, employing the gram, its multiples and subdivisions, just the same as with solids, thus avoiding the errors due to refraction, adhesion, and inaccurate measuring vessels. For practical purposes four grams of water may be regarded as equivalent to a fluid drachm of that liquid, and the same may be considered true of tinctures and infusions; syrups, on the average, are about one-third heavier than water, so that a fluid ounce of a syrup will be approximately represented by 43 grams.

If preferred, however, fluids may be prescribed by volume in the metric, just as in the present system, using for that purpose the *Cubic Centimeter*, that is, a volume represented by a cube all of whose sides measure one centimeter. An ordinary back-gammon die is usually about this size. One cubic centimeter (written 1 C. C.) = 16.231 minims. It is approximately regarded as one fourth of a fluid drachm.

APPROXIMATE EQUIVALENTS OF CUBIC CENTIMETER.

0.001	C. C.	=	$\frac{1}{65}$	minim.
0.01	"	=	$\frac{1}{6}$	"
0.1	"	=	$1\frac{1}{2}$	"
1.	**C. C.**	**=.....**	**15**	**minim.**
4.	"	=	1	fluid drachm.
16.	"	=	4	fluid drachms.
32.	"	=	1	ounce.

1000 C. C. (usually known as a **Liter**) is a trifle more than one quart, wine measure.

The following prescription—

R: Potassii bromidi, ℥i.
Elixir aurantii, fl., ℥viij.
M.

Would, in metric terms, be written:

Potassic bromide, 32
Orange elixir, 250
Mix.

Original Communications.

ARTICLE I.

ONE HUNDRED AND SIXTY-THREE CASES OF FRACTURE OF THE NECK OF THE FEMUR. COLLECTED AND REPORTED BY H. WARDNER, M.D., CAIRO, ILLS., Chairman of the Committee on Surgery, Southern Illinois Medical Association.

Fracture of the neck of the femur is a subject of special interest to all surgeons who have had cases under treatment. Having had my attention called to this subject, I addressed a circular to quite a large number of the older practitioners, asking for reports of such cases as may have come under their observation.

In response I received reports, more or less in detail, of 163 cases which are embodied in the following tabulated statement. One hundred and three of these cases are reported as having occurred within the capsule, sixteen as being both intra and extra capsular, thirty-six as extra capsular, one as a separation of the epiphysis, and seven as uncertain.

Name of Surgeon.	No. of Patient.	Sex.	Age when it Occurred.	Date of Occurrence.	Character of Fracture.	Right or Left Side.	Extra or Intra-Capsular.	TREATMENT. What application or dressing was used? When first seen by Surgeon, Etc., Etc.	RESULT. Union or Non-Union, Ligamentous or Bony. Amount of Shortening. Degree of Usefulness.
P. A. Allaire	1	F.	97	1873.	Simple.	R.	Intra.	No appliance used.	Got up very well, and lived to 101 years.
P. A. Allaire	2	F.	86	1875.	Simple.	L.	Intra.	No appliance used.	Died of exhaustion in 8 days.
P. A. Allaire	3	F.	75	1876.	Simple.	L.	Intra.	No appliance used.	Died of exhaustion in 30 days.
A. T. Bartlett	4	F.	57	Dec. 2d, 1867.	Simple, obscure.	R.	Intra.	Seen soon after accident. Hodgen's splint.	Ligamentous union. 1.2 Cm. shortening.
S. C. Plummer	5	F.	65	Feb. 20th, 1875.	Simple. Transverse.	R.	Intra.	15 hours after injury. Truesdale's fracture-bed.	Bony union. No shortening.
J. H. Reeder	6	F.	58	1872.	Simple.	R.	Intra.	4 to 6 weeks in double inclined plane with extension by weight from knee, followed by reclining chair, and no restraint.	Union ligamentous *probably*. Limb quite useful. 5 Cm. shortening.
H. Culbertson	7	F.	73	July 5th, 1858.	Simple.	L.	Intra.	Simply supported on pillows.	Non-union. New joint formed. Used crutch. Died in 1866, of senile gangrene. Shortening 3.7 Cm.
S. C. Plummer	8	F.	77	Feb. 5th, 1871.	Simple.	R.	Intra.	Truesdale's fracture-bed.	Non-union. Died in 21 days of old age.
S. C. Plummer	9	F.	78	Aug. 15th 1873.	Simple. Transverse. Oblique.	R.	Intra.	Truesdale's fracture-bed.	Perfect union in 42 days, but patient died of old age and confinement in treatment.
H. Wardner	10	M.	65	January, 1859.	Simple.	R.	Intra.	Seen soon after injury. McIntyre's splint, and double inclined plane.	Union probably ligamentous. Walked with cane after two years. Shortening not determined.
H. Wardner	11	F.	69	March 14 1872.	Simple.	R.	Intra.	Seen at once. Extension by weight and pulley.	Non-union, or possibly ligamentous. Uses crutch. About 5 Cm. shortening.
H. Wardner	12	M.	16	1876.	Simple.	R.	Intra.	Hodgen's splint, and plaster Paris.	Bony union. Walks with cane. Shortening but little, and not determined.
L. Dyer	13	F.	60		Simple.	—	Intra.	Physick's modified splint.	Non or ligamentous union. Walks with crutch. 5 Cm. short.
P. A. Allaire	14	F.	62	1874.	Simple.	R.	Intra.	No appliance used.	Limb useful with a cane.

Name of Surgeon.	No. of Patient.	Sex.	Age when it Occurred.	Date of Occurrence.	Character of Fracture.	Right or Left Side.	Extra or Intra-Capsular.	TREATMENT. What application or dressing was used? When first seen by Surgeon, etc., etc.	RESULT. Union or Non-Union, Ligamentous or Bony. Amount of Shortening. Degree of usefulness.
A. E. Bell	15	F.	62	Jan. 29th, 1867.	Simple.	R.	Intra, with free laceration of ligament.	No splints. Simple dressings.	Non-union. False joint. 3.1 Cm. shortening.
D. A. K. Steele	16	F.		April 22d, 1876.	Simple.	L.	Intra.	Seen night following the injury. Buck's apparatus with weight and pulley.	Non-union. Eversion Limb nearly useless. Spindle-celled sarcoma removed from over tensor vaginæ femoris 18 months after. About 2.5 Cm. short.
M. M. Goodman	17	F.	80	1871.	Simple.	R.	Intra.	No dressings except liniments.	Non-union. Limb about useless. But little shortening.
Saml. H. Birney	18	F.	56	July 8th, 1872.	Simple. Transverse.	R.	Intra.	Seen 3 hours after injury. Double inclined plane of Daniel's fracture-bed.	Union bony. Good use of limb. 2.5 Cm. short.
L. Dyer	19	M.	50		Simple.	—	Intra.	Physick's splint modified. Extension and counter-extension.	Union ligamentous *probably*. Walks with crutch. 5 Cm. short.
L. H. Stroud	20	F.	50	Oct. 1876.	Simple.	L.	Intra.	Supposed to have been a contusion. No dressing used.	Non-union. But little use.
G. Callen	21	F.	30	1865.	Simple.	R.	Intra.	Bathed with camphor !	Supposed to be ligamentous. Helpless without crutches. 5 Cm. short.
Chas. Richards	22	F.	84	1866.	Simple. Transverse.	R.	Intra.	Seen 4 hours after injury. Long splint and bandage.	Union ligamentous probably. Walked with crutches. Shortening not measured.
Chas. Richards	23	F.	61	1870.	Simple. Transverse.	L.	Intra.	Seen 2 hours after injury. Long splint and bandage.	Union ligamentous (?) No use of limb. 7.6 Cm. short.
Chas. Richards, and J. Casey	24	F.	58	1877.	Simple. Transverse.	L.	Intra.	Seen 2 hours after injury. Long splint and bandage.	Had no use of limb to time of death, 3 months later. 5 Cm. shortening.
M. A. McClelland	25	F.	60	1871.	Simple. Transverse.	R.	Intra (probably).	Was first seen by a "doctor" who pronounced it a sprain. No dressing whatever.	Union ligamentous. Walks with crutch. Shortening not determined.
J. H. Reeder	26	F.	65	1870.	Simple. Transverse.	R.	Intra.	Double-inclined plane 4 to 6 with weight extension from knee. Afterward reclining chair and no restraint.	Union ligamentous, probably. Limb useful. 3.7 Cm. short.
C. H. Mastin	27	M.	64	1875.	Simple.	L.	Intra.	Seen at once. Amesbury's double inclined plane.	Union ligamentous. Walks very well.

Name of Surgeon.	No. of Patient.	Sex.	Age when it Occurred.	Date of Occurrence.	Character of Fracture.	Right or Left Side.	Extra or Intra-Capsular.	TREATMENT. What application or dressing was used? When first seen by Surgeon, etc., etc.	RESULT. Union or Non-union, Ligamentous or Bony. Amount of Shortening. Degree of Usefulness.
W. Meacher	28	M.	70	1872.	Simple.	R.	Intra.	Placed on pillows.	Non-union (probably ligamentous). Could walk with cane.
W. Meacher	29	F.	60	1871.	Simple.	R.	Intra.	Placed on pillows.	Non-union. Could walk with cane. 1.2 Cm. shortening.
W. Meacher	30	F.	25	1875.	Simple.	L.	Intra.	Extension by weight and pulley.	Union ligamentous. Walks with cane. 1.2 Cm. shortening.
D. B. Trimble	31	M.	80	1858.	Simple.	L.	Intra.	Caused by lifting. Lived 5 months.	Non-union.
D. B. Trimble	32	M.	75 to 80	1860.	Simple.	R.	Intra.	Jumped from second story window. Lived 6 weeks.	Non-union.
D. B. Trimble	33	F.	90	1863.	Simple.	—	Intra.	Caused by pulling open a bureau drawer.	Died in 2 days.
E. R. Willard	34	M.	35	Jan. 5th, 1874.	Supposed impacted.	L.	Intra.	Long splint.	Union probably ligamentous. Usefulness good. 3.7 Cm. short.
E. R. Willard	35	F.	32	Sept. 28, 1874.	Simple.	L.	Intra.	Long splint.	Union probably ligamentous. Good use. 1.2 Cm. short.
Chas. T. Parkes	36	F.	72	October, 1874.	Simple. Oblique.	R.	Intra, probably.	Seen after 4 hours. Double inclined plane 2 weeks. Confinement not insisted on.	Union ligamentous. Walks with crutch and cane. 3.7 Cm. short.
J. H. Ledlie	37	M.	74	April, 1868.	Simple.	L.	Intra.	No dressing.	Died in a few days. Never rallied from shock.
A. G. Williams	38	M.	61	Aug. 1st, 1871.	Simple.	L.	Intra.	Seen soon after accident. Long splint and extension.	Union ligamentous. Limb nearly useless. 2.4 Cm. short. Eversion.
R. G Bogue	39	F.	90	Mch. 7th, 1876.	Simple.	L.	Intra.	Limb flexed and laid over padded blanket under knee.	Died of exhaustion April 2d, 1876.
R. G. Bogue	40	F.	92	Dec. 4th, 1876.	Simple.	L.	Intra.	Limb flexed with a pillow under knee.	Died of exhaustion Jan. 2, 1877.
F. L. Wadsworth	41	F.	75	N'v. 30th. 1877.	Simple.	R.	Intra.	Limb flexed with a pillow under knee.	Non-union. Uses crutches since the sixth week.
Henry Tomboken	42	F.	82	Jan. 10th, 1878.	Simple.	R.	Intra.	Same treatment as above.	Non-union. Not useful; but not painful.
R. W. Crothers	43	M.	80	Febru'ry, 1876.	Simple.	L.	Intra.	Same as above.	Non-union Limb useless. Died the following year.

Name of Surgeon.	No. of Patient.	Sex.	Age when it Occurred.	Date of Occurrence.	Character of Fracture.	Right or Left Side.	Extra or Intra-Capsular.	TREATMENT. What application or dressing was used? When first seen by surgeon. etc., etc.	RESULT. Union or Non-Union, Ligamentous or Bony. Amount of Shortening. Degree of usefulness.
R. L. Moore	44	F.	81	Sept. 15, 1874.	Comminuted.	L.	Intra.	Seen 4 days after injury. Extension by weight and pulley, and double inclined plane.	Death on 18th day from exhaustion.
R. L. Moore.....	45	F.	69	Oct. 15, 1874.	Simple.	L.	Intra.	Seen ten days after occurrence. Extension by weight and pulley, and sole leather splint.	Union ligamentous. Always used crutches. Shortening not known.
R. L Moore.....	46	F.	73	June 5, 1875.	Impacted.	R.	Intra.	Seen soon after accident. Double inclined plane with weight and pulley.	Died on 54th day, from septicæmia. Autopsy verified diagnosis.
M. L. Hall, reported by G. W. Jones.....	47	F.	76	Feb. 28, 1877.	Impacted.	R.	Intra.	No treatment allowed by patient.	Ligamentous union. Some usefulness. 3 Cm. short.
A. C. Rankin.....	48	M.	81	Jan. 1st, 1874.	Simple.	R.	Intra.	Long straight splint was used 8 weeks.	Non-union. Limb useless and painful. Died at end of one year.
Wm. T. Kirk.....	49	F.	63	March 5, 1873.	Simple.	L.	Intra.	Seen early. On 3d day placed limb in fracture box with side splints extending to axilla and perineum, with extension. Kept in bed three months.	Union bony. Walked without crutch or cane after 18 months. 2.4 Cm. short.
J. H. Ledlie	50	F.	58	Nov., 1858.	Simple.	L.	Intra.	Seen immediately. Double inclined plane and pillows.	Union ligamentous. Used crutches. 7.6 Cm. short.
R. Boal and J. C. Frye	51	M.	30	Dec. 12, 1868.	Simple.	L.	Intra.	No dressings.	Probably bony. Walks with cane. 3.1 Cm. short.
Wm. M. Chambers...	52	F.	71	1855.	Simple.	L.	Intra.	Sir Astley Cooper's method. No dressings.	Non-union. Walked with cane or crutch. 5 Cm. short.
Wm. M. Chambers...	53	F.	69½	Feb. 23, 1878.	Simple.	L.	Intra.	No dressings.	Non-union. Walking with crutches. Shortening unknown.
No Surgeon.....	54	F.	71	1873.	Simple.	L.	Iutra.	No treatment.	Non-union. 5 Cm. short.
H. W. Kendall.....	55	F.	69	Sept., 1866.	Simple.	R.	Intra.	Cause, tripped on carpet. Weight and pulley, 3 months in recumbent position. [See note.]	Limb quite useful. Walks with cane. Union Ligamentous. 6.3 Cm. shortening.
H. W. Kendall.....	56	F.	43	August, 1877.	Simple.	R.	Intra.	Weight, pulley and long splint.	Unable to walk without crutches. Non-union. 2.5 Cm. short.

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S. L. Cheaney	57	F.	98	Sept. 2, 1870.	Simple.	R.	Intra. (?)	Sand bags and rest.	Was able to get about with a ligamentous union.
Wm. B. Alley	58	M.	78	June, 1861.	Simple.	L.	Intra.	Seen after a few days. No dressings.	Union ligamentous. Walked only on crutches. 5 Cm. short.
Wm. B. Alley	59	F.	82	Sept., 1863.	Simple.	L.	Intra.	Seen at once. Hagedorn's (?) apparatus.	Union ligamentous. Used crutches 7 years before death. 5 Cm. shortening.
Wm. B. Alley.....	60	M.	75	Dec., 1871.	Impacted.	R.	Intra.	Same as above.	Union supposed to be ligamentous. 6.3 Cm. short.
Theodore Meyer	61	F.	45	May 4, 1849.	Simple.	R.	Intra.	Seen early. Spica bandage with starch and glue.	Probably union (ligamentous?). Used crutches last heard from; but doing well.
C. K. Hendee.....	62	F.	59	Sept., 1869.	Simple.	R.	Intra.	Seen 10 days after injury. Splint with extension and counter-extension.	Union ligamentous. Can walk with cane. 3.7 Cm. short.
C. K. Hendee.....	63	F.	68	Feb., 1875.	Simple.	R.	Intra.	Seen 3 months after injury. No dressing.	Union ligamentous. Uses crutch. 7.6 Cm. short.
C. K. Hendee.....	64	M.	62	Jan'y, 1877.	Simple.	R.	Intra.	No dressing except straw bolsters to keep leg from twisting.	Union ligamentous. Walks with cane. 5 Cm. short.
R. Roskoten.....	65	F.	70	1868.	Simple.	R.	Intra.	Seen after 8 weeks. Was first treated for dislocation by attending physician. No dressing when seen by me.	Non-union.
Kingkade, rep'ted by Dr. D. O. Morrell ..	66	M.	75	Sept. 14, 1877.	Simple.	R.	Intra.	Seen 6 weeks after injury. Hodgen's extension splint and plast. Paris.	Non-union.
A S. Munsell, rep'ted by F. A. Emmons..	67	F.	80	Jan. 25th, 1875.	Simple.	R.	Intra.	Seen 2 weeks after injury. Extension.	Non-union. Cannot move limb. 1.8 Cm. short.
Chas. T. Parkes.....	68	F.	76	Sept., 1877.	Simple.	L.	Intra.	Seen within 24 hours. No special dressings. Arranged on pillows.	Non-union probably. Can move limb. No pain. Bed ridden from old age.
R. W. Crothers	69	F.	60	Jan'y, 1859.	Simple.	R.	Intra.	Seen in 3 hours. Bandage, extension and wet paste board from knee to crest of ilium.	Ligamentous union. Walks with cane or crutch. Shortening not perceptible.
R. W. Crothers	70	F.	63	Jan'y, 1866.	Simple.	L.	Intra.	Seen within half an hour. Dressing same as above.	Union ligamentous. Walks with crutch or cane. Shorten'g not obsrvd.

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I. N. Danforth.....	71	M.	70	1865.	Simple.	R.	Intra.	Patient was a physician, and a very impatient patient. Starch dressing only.	Osseous union. Walks with cane. 2.4 Cm. shortening.
I. N. Danforth.....	72	F.	60	1864.	Simple.	R.	Intra.	Elevation foot of bed. Sand-bags, weight and pulley.	Osseous union. Walks with a little limp. 1.8 Cm. shortening.
C. H. Mastin.....	73	F.	8	———	Simple.	R.	Intra. Supposed separation of Epiphysis.	Seen several months after union. Kape's apparatus for fracture of hip.	Walks well with splint. 2.7 Cm. shortening.
C. H. Mastin.....	74	F.	60	Dec., 1877.	Simple.	L.	Intra.	Inclined plane and weight for several weeks. Rest in bed.	Ligamentous union. Walks with crutches.
C. H. Mastin.....	75	F.	58	July, 1876	Simple.	L.	Intra.	15 months after occurrence applied Agnew's splint for coxalgia, with perineal band.	Cannot walk without apparatus. Does very well with it. 2.4 Cm. shortening.
Wm. B. Alley.....	76	F.	76	Sept. 1876	Simple.	L.	Intra.	No dressing.	Died in 10 days of pneumonia.
J. L. Miller, reported by J. S. Whitmire..	77	F.	50	Dec., 1852.	Simple.	———	Intra.	Suppose simplest kind, as the surgeon was too penurious to procure proper apparatus.	No union whatever. Never walked without crutches. 10 Cm. shortening.
E. L. Marshall.....	78	F.	62	October, 1857.	Simple.	R.	Intra.	Seen 4th day. Daniel's fracture-bed.	Union ligamentous (?) Nearly useless. 3.7 Cm. short.
E. L. Marshall.....	79	F.	61	Aug. 30, 1875.	Impacted.	R.	Intra.	Rest, and sand bags.	Ligamentous perhaps. Walks with ease with cane. Slight shortening.
D. S. Booth.....	80	F.	55	1865.	Simple.	L.	Intra.	Foot of bed raised 2½ inches. Extension by weights. Sand bag support.	Union Ligamentous. Amount of shortening undetermined.
D. S. Booth.....	81	F.	60	1872.	Simple.	L.	Intra.	Same as above.	Same as above.
A. J. Mead.....	82	F.	68	1863.	Simple.	R.	Intra.	Seen 3 months after accident. No dressings.	Union Ligamentous. But little use. 3.7 Cm. short.
M. J. Roeschlaub.....	83	M.	42	June 19, 1851.	Simple.	R.	Intra?	Double inclined plane after Dupuytren and Richards. Seen within an hour.	Union bony. Useful. 0.6 Cm. short.
S. L. Cheaney.....	84	F.	56	Aug. 1st, 1867.	Simple.	R.	Intra?	Long spilnt with heavy weights.	Union bony. Quite useful after six months. Shortening undetermined.

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Allin & Sams	85	F.	55	Sept., 1855.	Simple.	L.	Intra.	Extension at first, but discontinued 3d day, too painful.	Union ligamentous probably. Limb useless. 1.8 Cm. short, and 4 years after 3.7 Cm. short.
John Schmidt	86	M.	62	1874.	Simple.	L.	Intra.	No dressing. Recumbent posture.	Limb quite useful with raised heel. 3.7 Cm. short.
W. H. H. King	87	F.	61	July, 1874.	Simple.	L.	Intra.	No dressing. Recumbent position.	Union ligamentous. Walks with crutch and cane.
E. Gaylord	88	F.	67	Jan. 25, 1870.	Impacted.	L.	Intra.	No dressing. Recumbency.	Union bony. Slight eversion. 2.4 Cm. short.
E. Gaylord	89	F.	84	Oct. 31, 1874.	Impacted.	L.	Intra.	No dressing. Recumbency.	Union bony. Some lameness. 3.7 inches short.
Thomas Whitten	90	F.	74	Dec. 20, 1876.	Simple.	L.	Intra.	Seen one week after accident. Extension with long splint.	Union ligamentous. Usefulness much impaired. 3.7 Cm. short.
W. J. Chenoweth	91	M.	70	Nov., 1873.	Simple.	R.	Intra.	Long splint and roller.	Non-union. Patient delirious and would not endure dressings.
H. C. Howard	92	F.	52		Simple.	R.	Intra.	Extension and rest.	No union.
Chas. C. F. Gay	93	F.	60	1871.	Simple.	L.	Intra.	Fracture and shortening, only recognized after some weeks, after tripping on the carpet. No dressings used.	Non-union. Shortening 6.3 Cm.
Chas. C. F. Gay	94	M.	52	1875.	Simple.	L.	Intra.	Extension.	Non-union. Shortening 1.8 Cm. Subsequently died of cancer of stomach.
Chas. C. F. Gay	95	M.	67	March 5, 1870.	Simple.	L.	Intra.	Extension by weight and pulley.	Non-union. 1.8 Cm. shortening.
Chas. C. F. Gay	96	M.	32	June 8, 1870.	Simple.	L.	Intra.	Extension by weight and pulley.	Non-union. Shortening 2.5 Cm.
Chas. C. F. Gay	97	M.	61	1875.	Simple.	L.	Intra.	Fell striking on hip. No dressings.	Non-union. 5 Cm. shortening.
Chas. C. F. Gay	98	M.	64	October, 1876.	Simple.	R.	Intra.	Large man, fell striking on left hip. No dressings.	Non-union. 4.7 Cm. short. Died 9 months after injury.
H. T. Montgomery	99	F.	70	1871.	Simple.	L.	Intra	Foot of bed 9 inches high. 12 to 16 pounds over pulleys, two parallel.	Union. Walked in 18 months. 1.8 Cm. short. No splint used.

Name of Surgeon.	No. of Patient.	Sex.	Age When it Occurred.	Date of Occurrence.	Character of Fracture.	Right or Left Side.	Extra or Intra-Capsular.	TREATMENT. What application or dressing was used? When first seen by Surgeon, etc., etc.	RESULT. Union or Non-union, Ligamentous or Bony. Amount of Shortening. Degree of Usefulness.
Abner Hard.....	100	M.	70	1855.	Simple. Transverse.	R.	Intra.	Seen immediately after injury. First used long splint, but soon changed to pulley and weight and continued to recovery.	Ligamentous union probably. Little shortening. Patient first went on crutches, but finally with cane. Useful leg.
Abner Hard.....	101	F.	63	1858.	Simple. Transverse.	R.	Intra.	Seen soon after fracture occurred. Treated by pulley and weight till recovery.	Suppose ligamentous union. Little shortening. After first year was able to go without crutch or cane. Useful limb.
Abner Hard.....	102	F.	64	Dec. 1, 1866.	Simple. Transverse.	R.	Intra.	Seen soon after injury. Treated by pulley and weight.	Suppose ligamentous union. Little shortening. Went first with crutch and then with cane. Useful limb.
Abner Hard.....	103	F.	78	Sept. 14, 1877.	Simple. Transverse.	R.	Intra.	Seen soon after injury. Pulley and weight and subsequently by starch bandage.	Do not know as to union. Patient is using crutches and improving steadily. Little shortening.
H. Wardner.....	104	F.	56	1877.	Simple.	R.	Intra and perhaps partly Extra	Hodgen's splint and plaster Paris.	Union seems to be bony. Walks now with crutch. 0.6 Cm. short. A little eversion.
E. L. Marshall.....	105	F.	65	July 5, 1860.	Simple. Oblique.	L.	Intra and Extra.	Seen seventh day. Daniel's fracture bed.	Probably bony. Walked with cane. 5 Cm. short.
Chas. T. Parkes.....	106	F.	45	Nov., 1876.	Simple. Oblique.	R.	Intra and Extra.	Seen within 24 hours. Extension by weight and pulley and long external splint.	Good bony union. Useful limb. 2.5 Cm. or more short.
Chas. T. Parkes.....	107	M.	42	Febru'ry, 1878.	Impacted.	R.	Intra and Extra.	Weight and pulley and sand bags.	Bony union. Good limb; *some limp.* 1.8 Cm. short.
Chas. T. Parkes, Cook Co. Hospital	108	M.	40	1877.	Simple. Oblique.	L.	Intra and Extra.	Weight and pulley.	Bony union. Good limb. 0.6 Cm. short.
Chas. T. Parkes.....	109	M.	65	March, 1875.	Simple. Oblique.	L.	Intra and Extra.	Seen within 24 hours. Weight and pulley and long external splint.	Union bony. Useful but lame. 2.1 Cm. short.
S. C. Plummer and G. G. Craig.....	110	M.	49	March, 1871.	Simple. Oblique.	R.	Extra and Intra.	24 hours after injury. Truesdale's fracture bed.	Bony union. Perfect use. Longer than opposite limb.
I. N. Danforth.....	111	F.	68	1875.	Simple.	L.	Oblique, Extra and Intra.	Weight and pulley extension. Blankets and splints.	Union not certain; believed to be bony. Walks well but complains of weakness. 2.5 Cm. shortening.

Name of Surgeon.	No of Patient.	Sex.	Age When it Occurred.	Date of Occurrence.	Character of Fracture.	Right or Left Side.	Extra or Intra-Capsular.	TREATMENT. What application or dressing was used? When first seen by Surgeon, etc., etc.	RESULT. Union or Non-Union, Ligamentous or Bony. Amount of Shortening. Degree of Usefulness.
F. M. Agnew	112	F.	70	May, 1869.	Simple.	R.	Extra and perhaps Intra.	Straight splint, perfect rest.	Union bony. Walks very well with a cane.
C Richards	113	M.	22	1874.	Simple. Oblique.	R.	Extra and Intra.	Sole leather splint and weight for extension.	Bony union. Motion impaired. Fair use. No shortening.
R. P. Lane, reported by G. W. Rohr	114	F.	54	1877.	Simple. Oblique.	R.	Extra and Intra.	Weight and pulley.	Union bony. 3.1 Cm. short.
Various Army Surgeons	115	M.	40	July 19, 1864.	Compound.	R.	Extra and Intra.	Seen at once. Laid on well side. Cooling lotions. No splints. See note.	Bony union. Usefulness impaired. 3.1 Cm. short.
H. C. Howard	116	F.	58		Simple.	L.	Extra and Intra.	Extension, immobility, rest.	Good recovery. 1.8 Cm. short.
H. C. Howard	117	F.	45		Impacted.	R.	Not certain.	Splints, immobility. No extension.	3.7 short.
Joseph Teft	118	M.	75	1855.	Oblique.	R.	Extra and Intra.	No treatment.	Non-union.
D. Prince	119	M.	35	April 8, 1875.	Simple, Impacted.	R.	Extra and Intra.	Hodgen's splint. Seen 20 days after injury.	Death, 25 weeks after injury, from drinking liniment containing sulphuric acid, while in delirium tremens.
Drs. Howell, reported by Abner Hard	120	M.	68	1876.	Simple. Transverse	R.	Extra.	No dressing. Fracture was not detected for several months; supposed to be a contusion.	Non-union. Shortening 6.3 Cm. No use of limb. Moves by use of crutches.
D. A. K. Steele	121	M.	—	April 25, 1877.	Impacted.	L.	Extra.	Seen 3 days after injury. Hodgen's splint.	Bony union. Very useful limb. No lameness. 0.6 Cm. short.
Saml. H. Birney	122	M.	64	Jan. 12, 1874.	Comminuted.	R.	Extra.	6 hours after fracture. Recumbency, extension by weight and pulley.	Bony union. Eversion. Walks well with cane. 3.7 Cm. short.
Saml. H. Birney	123	M.	3	Jan. 2, 1878.	Comminuted.	R.	Extra.	Seen 5 days after injury. Double, straight thigh splints. Extension by weight and pulley.	Bony union. Began to walk st end of 5 weeks. Not over 1.2 Cm. short.
Z. C. McElroy	124	F.	55	1855.	Simple. Obscure.	L.	Extra.	No apparatus. Placed on pillows.	No union by bone. Walked on crutches 15 years, and died of pneumonia. 5 Cm. short.
J. Stonemetz	125	M.	12	1862.	Simple. Transverse.	L.	Extra.	Liston's splint.	Bony union. Perfect use. No perceptible shortening.

Name of Surgeon.	No. of Patient.	Sex.	Age When it Occurred.	Date of Occurrence	Character of Fracture.	Right or Left Side.	Extra or Intra-Capsular.	TREATMENT. What application or dressing was used? When first seen by Surgeon, etc., etc.	RESULT. Union or Non-Union, Ligamentous or Bony. Amount of Shortening. Degree of Usefulness.
Chas. Reber	126	F.	65	1872.	Simple.	L.	Extra.	Seen 24 hours after accident. Extension by weight and pulley.	Union ligamentous. Can walk with cane or crutch. 2.5 Cm. shortening.
W. Meacher	127	M.	60	1873.	Simple.	L.	Extra.	Sand bags. Extension by weight and pulley.	Good recovery. Walks well. 0.6 Cm. short.
J. R. Wells	128	F.	60	Dec. 19, 1874.	Simple.	L.	Extra.	Truesdale's fracture bed.	Union bony. Perfect use. No perceptible shortening.
H. Culbertson	129	M.	27	July 10, 1854.	Simple, with dislocation of ankle same side, and simple fracture of both bones of left leg.	R.	Extra. Note.	Double inclined plane. Extension could not be borne. Supported by pillows.	Union bony. Limb useful. 6.3 Cm. short.
R. Roskoten	130	M.	51	Jan. 14, 1858.	Simple, with contusions.	L.	Extra.	Dzondis' apparatus, improved by Hagedorn, for extension, and the splint of Burminghasen to support fracture in the proper position.	Bony union. Good use of limb. 1.8 Cm. short.
Fred. Brendel	131	M.	44	Nov. 22, 1869.	Simple.	R.	Extra.	Straight splint and extension.	Union bony. Tolerably good use of leg, which was shortened by a previous fracture. Total shortening 3.7 Cm.
A. J. Mead	132	F.	70	1856.	Simple.	L.	Extra.	Seen at end of 4 months. No dressings.	Union ligamentous. Never walked without crutch. 5 Cm. shortening.
J. Stout	133	F.	70	March 19, 1869.	Simple.	R.	Extra.	Extension by weight.	Union bony. Limb useful. 1.8 Cm. shortening.
C. B. Reed	134	M.	70	Sept. 28, 1866.	Simple.	R.	Extra.	Seen 3 hours after injury. Limb supported by cushions.	Ligamentous union. Usefulness much impaired. 5 Cm. shortening.
Chas. Reber	135	F.	63	1869.	Simple.	R.	Extra.	Seen in 6 hours. Extension by weight and pulley.	Ligamentous union. Walks with cane or crutch. 2.5 Cm. shortening.
W. J. Chenoweth	136	F.	19	Aug. 28, 1877.	Impacted.	R.	Extra.	Long splint and roller.	Good union. No appreciable shortening.
W. J. Chochran	137	M.	52	January, 1876.	Impacted.	L.	Extra.	No displacement. Long splint and rest.	Bony union. Slight eversion of foot. 1.2 Cm. short. Walks with cane.
J. H. Ledlie	138	M.	20	April 10, 1862.	Compound, G. S. W.	L.	Extra.	Seen one month after accident. Extension with weight and pulley.	Union bony; joint anchylosed. Good use. 3.7 Cm. short.

Name of Surgeon.	No. of Patient.	Sex.	Age When it Occurred.	Date of Occurrence.	Character of Fracture.	Right or Left Side.	Extra or Intra-Capsular.	TREATMENT. What application or dressing was used? When first seen by Surgeon, etc., etc.	RESULT. Union or Non-Union, Ligamentous or Bony. Amount of Shortening. Degree of Usefulness.
T. M. Sams	139	F.	36	Dec., 1849.	Impacted.	R.	Extra.	Long splint and extension.	Good union; bony. Useful but imperfect. 1.2 Cm. short.
F. B. Haller	140	M.	70	1852.	Simple.	R.	Extra. Anatomical neck. (?)	Seen 4 hours after injury. Straight splint.	*Died* 3rd day from internal injuries.
C. H. Richings, reported by G. W. Rhor.	141	F.	55	1872.	Simple. Transverse.	L.	Extra.	Long straight splint.	Union bony. No perceptible shortening.
B. K. Lucas	142	M.	71	Jan. 9, 1877.	Simple.	R.	Extra.	Extension by weight and pulley at once.	Bony union. Can walk long distance. 1.2 Cm. short.
Josiah Whitnel	143	M.	43	1858.	Simple.	L.	Extra.	Seen first day. Used Day's splint.	Bony union. 1.2 Cm. short.
Josiah Whitnel	144	M.	70	1866.	Simple.	R.	Extra.	Seen 2 months after injury. No dressings used.	Union ligamentous. 7.5 Cm. short.
Josiah Whitnel	145	M.	69	1866.	Simple.	R.	Extra.	Seen first day. Used Day's splint.	Non-union.
Wm. M. Chambers and A. Evans	146	M.	40	1850.	Simple.	L.	Extra.	Liston's splint.	Non-union (ligamentous?). Walked with cane. 3.7 Cm. short.
Wm. H. H. King	147	F.	58	August 2, 1870.	Simple.	R.	Extra.	Seen in a few hours. Dressed with weight and pulley.	Union bony. 1.8 Cm. short.
Drs. Monroe and Speed	148	M.	35	May 29, 1872.	Simple. Transverse.	R.	Extra.	Seen at once. Dressed in Day's splint (?) with extension and counter-extension.	Union supposed to be bony. Patient *died* in six months of phthisis. Shortening 1.2 Cm.
Chas. C. F. Gay	149	M.	27	May, 1874.	Simple and comp'nd fracture of tibia	L.	Extra.	Fell from a boat. Extension simply.	Non-union. 1.8 Cm. short.
Chas. C. F. Gay	150	M.	55	October, 1874.	Simple.	L.	Extra.	Extension.	Bony union. 5 Cm. short. Walks with cane and high heel.
H. F. Montgomery	151	F.	25		Simple.	L.	Extra.	Long splint with screw extension.	United. 2.2 Cm. short.
Chas. C. F. Gay	152	F.	24	1877.	Simple.	R.	Cervix, part not stated.	No statement.	Non-union. Shortening 5 Cm. Toes everted. Limb much atrophied.
J. F. Stewart	153	F.	3	April 22, 1871.	Simple.	R.	Extra.	Seen at once. Applied simple straight splint.	Bony union. No perceptible shortening. Perfect use.
J. F. Stewart	154	M.	56	Feb. 17, 1873.	Simple.	R.	Extra.	Seen at once. Extension by weight and pulley.	Bony union. Almost perfect use. 1.2 Cm. short.
J. F. Stewart and J. Murphy	155	M.	64	July 12, 1875.	Simple.	R.	Extra.	Seen at once. Straight splint and extension.	Bony union. Usefulness much impaired, but improving. 3.1 Cm. short.

Name of Surgeon.	No. of Patient.	Sex.	Age When it Occurred.	Date of Occurrence.	Character of Fracture.	Right or Left Side.	Extra or Intra-Capsular.	TREATMENT. What application or dressing was used? When first seen by Surgeon, etc., etc.	RESULT. Union or Non-Union, Ligamentous or Bony. Amount of Shortening. Degree of Usefulness.
Drs. Monroe and Speed.....	156	M.	9	June 18, 1876.	Simple. Transverse.	L.	Probably a separation of epiphysis.	Seen soon after accident. Physick's splint and junk bags.	Union bony. No apparent shortening. Usefulness perfect.
Edmund Andrews.....	157	M.	Ab't 60	Forgotten.	Simple.	R.	I do not know any way to make a decisive diagnosis on this point. Many cases are doubtless partly intra and partly extra capsular. I suppose those who got a bony union were probably *at least partly* extra capsular.	Side splint, adhesive straps, pulley and weight.	Apparently bony union. Able to walk well with cane.
Edmund Andrews.....	158	M.	Ab't 40	Forgotten.	Simple.	R.		Adhesive straps, pulley and weight.	Bony union. Good use.
Edmund Andrews.....	159	F.	36	Forgotten.	Impacted.	Forgotten.		Horizontal position only.	Bony union. Good use.
Edmund Andrews.....	160	F.	Ab't 60	———	Impacted.	L.		Horizontal position only.	Union doubtful. Imperfect use.
Edmund Andrews.....	161	M.	45	———	Simple.	Forgotten.		Adhesive straps, pulley and weight.	Bony union. Good use.
Edmund Andrews.....	162	M.	Ab't 35	———	Compound.	R.		Splints.	Bony union. Considerable use.
Edmund Andrews.....	163	M.	Ab't 38	———	Simple.	Forgotten.		Forgotten.	No union. Imperfect use.

DEAR DOCTOR: My records are imperfect on this subject. I send such as I am able to recall with distinctness. I distrust the precision of all attempts to diagnosticate extra from intra-capsular. In cases of old persons who fail of union, I generally presume the fracture is intra-capsular, but I doubt the certainty of the conclusion, even when corroborated by the other symptoms usually relied on to help out the inference.

The following table shows amount of shortening resulting from the different modes of treatment as reported:

MODE OF TREATMENT.	Total number of cases.	No. of cases in which the amount of shortening is given.	Maximum. Cm.	Minimum. Cm.	Average.	REMARKS.
No appliance used. Support on pillows..	48	21	10.	3.1	5.	Non-union 8, ligamentous 11, bony 21.
Extension by weight and pulley.....	42	34	6.3	.0	2.1	
Hodgen's modification of Smith's ant....	6	4	1.2	0.6	1.	
Truesdale's fracture bed.....	5	4	.0	.0		One longer than natural.
Daniels' fracture bed.....	3	3	5.	2.5	3.7	
Amesbury's double inclined plane.....	7	5	7.6	0.6	4.	
Straight splint, with extension after the manner of Physick.....	27	18	7.6	.0	2.	
Other apparatus of seven different kinds, but involving same principles as above	25	9	6.3	1.2	2.8	

Many eminent surgeons distrust accuracy of diagnosis in a majority of cases of this injury. The difficulty of correct diagnosis is very well illustrated in the case of Bergman vs. Volker, Superior court of Buffalo, N. Y., September term, 1876.

Plaintiff was sixty-one years old; was knocked into a gutter by a passing team, striking on left side, August 31st, 1875. Was lifted into a wagon and started home; stopped to see a doctor, who said it was only a bruise. At home, cried with pain in left hip when shoe and sock were removed. Four days later, called Dr. Walker, who diagnosticated and treated the injury as a bruise.

Dr. Gay saw the case 18th of May, 1876, made careful examination, and pronounced the case dislocation upon dorsum of ilium, and made what he supposed to be a reduction, but afterwards concluded the head of the bone had slipped into the sciatic notch.

Dr. Miner diagnosticated a fracture of the neck. Dr. T. F. Rochester ditto. Dr. James P. White diagnosticated fracture within capsular ligament. Dr. H. A. Hopkins diagnosticated dislocation into sciatic notch.

On March 22d, 1877, plaintiff committed suicide. A post mortem examination revealed the facts set forth in the following:

"This is to certify, that on the 22d day of March, 1877, we, the undersigned, made a post mortem examination of the left hip of Chas. Bergman, of this city. The head of the femur was in the acetabulum. There had been a fracture of the neck of the

femur, followed by its entire absorption. The shaft of the femur was united to the head by a long, strong ligament.

"(Signed), R. W. VAN PEYMA, M. D.,
Post Mortem Examiner of Erie Co., N. Y.
BERNARD BARTOW, M. D."

The examination was made in the presence of Drs. White, Miner, Rochester, Gay, Wycoff, Wetmore, Hauenstine, Diehl, Storck, W. W. Miner, Brush, Doggett, Hopkins, Folwell and others.

In regard to the modes of treatment, the results as given are favorable to the use of Hodgen's splint and Truesdale's fracture bed; but the number of cases reported is not sufficient to warrant a decisive opinion. My own experience in the use of the former has been eminently satisfactory. Those who have used the latter are enthusiastic in its praise.

Results are certainly in favor of treatment by appliances intended to retain the fragments in apposition.

I regret that time and the pressure of urgent duties prevent my making the study of these cases that I had intended when the subject was first entertained. I place them upon record, feeling that they will be of use to others whose attention may be drawn to the subject. I desire to acknowledge valuable aid from Dr. H. Y. Stalker, of Cairo, in tabulating the cases.

ARTICLE II.

A FATAL CASE OF INVERSIO PARTIALIS UTERI PUERPERALIS.*

By EDWARD WARREN SAWYER, Lecturer on Obstetrics and Diseases of Children, Rush Medical College, Chicago.

Mrs. B——, 38 Aldine square, æt. 35 years, of small, frail physique; multipara, last labor five years ago. She fell in labor at midnight, Dec. 19, 1877; an hour afterward, I saw her for the first time. I was struck by the unusual size of the abdomen, which suggested multiple pregnancy. The lower extremities

* Read before the Chicago Gynæcological Society, Nov 29, 1878.

were very œdematous, and had been in this condition for several months.

Upon examination, I found the os two-thirds opened, the vertex in advance, and still very high. Her pains, which returned with natural regularity and frequency, were short and sharp, lacking in force; they were not well borne by the patient, who frequently demanded ether.

At 2 a. m. the os was fully opened. Upon rupturing the membranes, there escaped the greatest quantity of liquor amnii I have ever encountered, the water inundating the bed and falling upon the floor. Her abdomen soon assumed the size usual to this moment. The head was well engaged in the excavation, in the third position of the vertex (R. O. P.), the anterior fontanelle occupying the centre of the field. In auscultating the tumor, I heard but one fœtal heart, on the median line just below the umbilicus; pulsations 144 in the minute. After waiting for several contractions of the uterus, which appreciably advanced the head, I began to allow the patient to inhale ether during the accession of each pain. During the intervals, she was quite conscious, and kept up an intelligible conversation with her husband and her attendant. The effect of this obstetrical degree of anæsthesia was most happy; the woman bore her pains without complaint, and they were noticeably increased in force, though still shorter and weaker than natural.

At 4:30 a. m. the occiput had rotated forward, into the second position, and the head was well engaged in the outlet of the canal. I now carried the anæsthesia to the surgical degree for a moment, applied my short forceps, and delivered the head within ten minutes. All ether was discontinued from this moment. There was a pause of at least five minutes, when I became solicitous for the infant, who did not close the gums upon my finger in the mouth, and so completed the extraction by hooking my finger into the left axilla. During this time, the husband, under my direction, was compressing the uterus with both hands; this compression he continued until relieved by me. The child required a vigorous slapping and cold douche before it would breathe.

After the lapse of about ten minutes—the woman in the

meantime seemed in a natural sleep—I passed my finger into the vagina, and found the placenta partly extruded through the mouth of the uterus; I completed its delivery with less difficulty than usually obtains. The patient wakened at this moment, and simply said, "Don't." I examined the abdomen, and felt the uterus very flaccid and reaching to the umbilicus, *but uniformly rounded.*

A few minutes later, not more than fifteen — the husband in the meantime keeping up compression—I noticed a pallor of the woman's face, who opened her eyes and yawned. I quickly raised the bed-covering, and saw that a rather brisk hæmorrhage was going on; the pulse was rapid and very feeble. I put my hand upon the belly, but *could not plainly feel the outlines of the uterus.* I sunk my hand deep downward, and had but little difficulty in compressing the aorta against the vertebral column, though the woman complained that my pressure was uncomfortable; this procedure completely arrested the hæmorrhage. As soon as the nurse could pour a teaspoonful of Squibb's fluid extract of ergot from a bottle, it was given to her. I called for ice, which was not in the house. While the husband went for ice, I slapped the abdomen with a cold wet towel. The dose of ergot was repeated twice in the next half hour.

Ice was soon procured, and I hastened to rub the epigastrium with a lump; I also passed a lemon-shaped piece into the vagina as far as the mouth of the uterus, which presented nothing unusual. The uterus immediately contracted, and its outlines were easily made out through the abdominal parietes; the upper border was not now rounded upward, as the fundus usually is, but was represented by a straight, hardened edge, extending transversely across the hypogastrium, at a point nearly midway between the symphysis pubis and umbilicus. This edge was quite like the rim of a bowl. At either side, and resting upon this rim, a spherical body, continuous with a rounded cord, could be easily felt (the ovary and tube).

It now flashed upon me that the fundus of the uterus had fallen downward into the cavity of the organ. This discovery was made about forty minutes after the delivery of the placenta, and some twenty-five minutes after I had once felt the fundus

flaccid, but rounded upward. I ceased my compression of the aorta, and no more blood was lost. From this moment, the uterus was in a state of tonic spasm, *as if completely ergotized.* At no time could I detect the slightest relaxation, though I longingly watched for this event.

I passed my hand into the vagina, and found the uterus unusually high; the os was opened to the extent of about four centimeters, and rigid. A segment of the prolapsed fundus could be felt looking through, and in contact with the open mouth. The contrast in the feel of this circular area of spongy fundus, with the smooth covering of the vaginal portion of the cervix, made it of easy recognition.

I shaped my hand into a cone, which I impinged against the fundus, through the os, at the same time making a *point d'appui* with my left hand upon the upper rim of the uterus, through the abdominal walls. In this manner I was enabled to exercise a degree of force in attempting to push the fundus upward, such as I feared would tear the uterine tissue; but I made no impression upon it; the organ felt like cartilage. The patient fainted during this effort at replacement; the pulse disappeared from the wrist, and I was obliged to desist. A dose of morphia, with brandy, was given by the mouth, and brandy was also thrown into the rectum. The trunk was surrounded with bottles of hot water, and frictions faithfully used; the foot of the bed was also raised. In a half hour, these measures were rewarded by a marked improvement; the color had returned to her face, and the pulse was quite strong at the wrist. I now made a second attempt at replacement, but with the same futile result; the poor woman complained of pain, and again fainted. The respiration soon became sighing; there was great jactitation, and our united efforts were required to keep her upon the bed. She was delirious, jumped from one side of the bed to the other, crying, "I shall be uncovered," and no efforts of ours could prevent her kicking herself naked. The *ensemble* constituted a scene which can never be effaced from memory.

All efforts at resuscitation were kept up faithfully, but without avail. The unfortunate lady soon became moribund, and died very quietly at eight o'clock, about three hours after delivery,

rather more than two hours after the inversion was recognized, and about one hour after the second effort at replacement of the fundus.

Dr. Byford reached the house some ten minutes before dissolution, and recognized the utter hopelessness of the case.

The abdomen was examined fifty-five hours after death, and the uterus, which was preserved, was found in the state already described. Its tissue was not torn. There was no difficulty in replacing the fallen fundus at this time.

The child was a male, and weighed ten pounds.

REMARKS.

This accident, which is one of the gravest that can befall a puerperal woman is, fortunately, one of extreme rarity; since it occurred but "once in upwards of 190,800 deliveries at the Rotunda Hospital." *

The result in this case was not exceptional.† Of seven cases seen by Hamilton, "in one single instance only the woman survived the shocking accident." ‡

It is a common observation, that the loss of blood and shock are greater in the incompletely inverted uterus, when the fundus is grasped by the body, than when the organ is turned quite inside out. § The most common variety is the incomplete ‖; hence the great mortality attending the accident.

The reflections suggested by the case in point are: first, as to the cause of the accident. The undue distension of the uterus by the liquor amnii undoubtedly weakened the uterine walls, so that, when the organ was emptied, the fundus could easily fall into the cavity of the body. This enfeeblement was recognized before delivery, through the short, sharp, weak pains. The almost universal observation made by the older authors, that inversion of the uterus is generally caused by the attendant dragging upon the cord of the undetached placenta, has absolutely no application here; for the placenta was entirely detached spontaneously. Second, as to the management of the accident.

* Playfair, Treatise of Midwifery, Philadel., 1876.
† Velpeau, Traité de l'art des Accouhemens, Paris, 1835.
‡ Hamilton, Outlines of Midwifery, Edinburgh, 1784.
§ Kilian, Die Operative Geburtshülfe, Bonn, 1835.
‖ Mauriceau, Traitié des Maladies des Femmes Grosses, Paris, 1740.

Writers agree upon the importance of immediate replacement of the inverted organ. Surely it is to the reposition of the organ that we are to look for a relief from dangerous shock, and security against hæmorrhage. As a rule, according to authors, the immediate replacement of the fundus is not difficult. But an insurmountable obstacle in the way of such success in this case was the condition of tonic spasm which at first seemed due to the administration of ergot. One cannot refrain from expressing a regret at this point, though it is true that the effects of ergot were indicated by the post-partum atony of the uterus. There is consolation in the fact, moreover, that some portion of the uterus is usually spasmodically contracted, when there is atony of the organ, when no ergot has been given. § ||

This patient succumbed to the shock incident to having the fundus grasped by the spasmodically contracted body of the uterus. The shock may have been augmented, under the circumstances, by the loss of blood; but I have more than once seen a greater hæmorrhage with no appreciable effects upon the woman.

ARTICLE III.

TRUE CROUP; OR, PSEUDO-MEMBRANOUS LARYNGITIS. By J. A. GOLDSBERRY, ANNAPOLIS, IND. Read before the Parke County, Ind. Medical Society.

True croup, sometimes called diphtheritic, exudative, fibrinous, is an inflammation of the mucous membrane of the larynx, with an exudation upon its surface of lymph or pseudo-membrane. It is a disease which may be said to be almost peculiar to childhood, as it rarely occurs in those under two or beyond seven years of age; no age, however, it seems, is absolutely exempt from it. It is confined to no latitude or country, but is endemic throughout the United States and all over the civilized world.

The causes which contribute to the occurrence of this fatal malady, are, I think, in many instances, obscure. The child of

§ Dewees, System of Midwifery, Phil., 1824.
|| Smith, Lectures on Obstetrics, Gardner, New York, 1858.

splendid *physique*, well fed and well clothed, living in the rural districts and surrounded by influences such as conduce to the highest degree of comfort and health, and the half-starved sickly offspring of the poor of our filthy and crowded cities, are alike subject to its attack. Some authorities are of the opinion that there exists in some children a predisposition to the disease, and that that predisposition may be inherited, which I think quite probable.

Boys are more frequently affected than girls. Unquestionably the most common exciting cause is exposure to cold; naturally then, we would expect it to occur to a greater extent in some localities than others.

A climate characterized by great and frequent fluctuations in temperature, with a cold and humid atmosphere, is productive of the disease; hence its frequency in this latitude. It is more common in the spring and winter months than in other seasons of the year. There are now and then instances in which the cause may be traumatic, as in the inhalation of scalding steam, or the swallowing of acrid and corrosive liquids. It occurs usually as a primary disease but not unfrequently it is secondary. In its secondary form it may come up in the declining stage of measles and small-pox; it may complicate diphtheria and scarlatina.

As this is, primarily at least, an acute inflammation of the larnyx, the parts affected present the usual anatomical morbid phenomena. The nature of the lesions is precisely such as results from inflammation of mucous surfaces in other parts of the body. The mucous membrane is hyperæmic, greatly thickened and usually loaded with mucus and pus. In mild cases a small surface only of the mucous membrane may be affected. In severe cases the inflammatory action extends *beneath* this membrane, involving the contiguous tissue, with the usual concomitants, serous infiltration and œdema; and from this latter condition arises one of the chief dangers. Many cases succumb to this disease, not so much by reason of the exudation as from the œdematous condition of the submucous structure. In cases of a severe grade the inflammation extends into the trachea and not unfrequently involves the bronchial tubes. The fauces may

likewise become affected. But the most important anatomical element in the disease, which gives to it its distinguishing characteristics, and which adds so much to its danger, is the formation of pseudo-membrane. Of course there can be no true croup without the presence of this exudation; divest it of this feature and you rob it of its principal terror. The extent of the false membrane is co-extensive with the inflammation. Wherever the mucous membrane is undergoing inflammatory action, whether it be in the larynx, pharynx, trachea or bronchial tubes, there we find, more or less, the fibrinous deposit. There is a difference of opinion among medical men as to the nature of these membranes. While there are some eminent pathologists who insist that they are composed of fibrin, there are others, no less distinguished, who claim that there is no fibrin in them, but that they are made up of "epithelial cells, which, undergoing some form of degeneration as they are pushed forward from the mucous surface, enlarge, and appear under the microscope, as irregular blocks interlacing with each other." But whatever may be their nature, whether fibrin or something else, all must agree that their presence in the air passages is fraught with the most imminent danger. Usually, in from five to six days, if the child survives so long, the false membrane begins to soften and break down from decomposition, and may be expelled in the act of vomiting or coughing. In fatal cases that have been examined after death, the lungs were invariably found to be more or less congested; portions of them, here and there, were collapsed, while not a few of the lobules were completely hepatized. The right cavities of the heart were also distended with blood, which from its dark color, was evidently unduly impregnated with carbon.

In the vast majority of cases this disease commences very much like a common cold or coryza, for which, unfortunately, it is often mistaken. There is more or less febrile excitement, cough, constipated bowels, impaired appetite, thirst, and the child is fretful and irritable. Very soon certain symptomatic features declare themselves which are highly characteristic of the disease.

The cough, which is always present from the very beginning, becomes hoarse, dry and ringing; some describe it as barking, suppressed, stridulous. While as just observed it is one of the

first symptoms, in intensity it varies greatly in different cases. I have treated cases in which, from first to last, there was comparatively little cough. Hoarseness and huskiness of the voice, like the cough, is generally one of the first observable symptoms; it persists throughout the disease, and in fatal cases, towards the close of life, the voice is entirely lost. There is usually more or less expectoration. In some cases it is abundant, in others scanty, depending upon the extent of surface involved in the inflammation. A characteristic feature of the sputum is its extreme toughness and tenacity, so much so, that it is often expelled with the greatest difficulty.

In the advanced stage of the disease, in favorable cases, the expectoration not unfrequently mixed with strips and patches of pseudo-membrane, becomes quite profuse and loses in a measure its former tough, tenacious element. The respiration is always accelerated, not to the extent however that we would expect; certainly not so much so as in other affections of the respiratory apparatus far less serious.

The pulse in the beginning varies in frequency from 120 to 130 beats per minute; in many cases is full and strong, while in others it is rapid and feeble.

As the disease progresses the gravity of the symptoms becomes marked and unmistakable. In consequence of the increasing laryngeal, and, it may be, tracheal obstruction, the breathing is labored and difficult. Along with the mechanical impediment to respiration there seems to be a neuropathic or nervous factor, which affecting the larnyx, produces spasmodic contraction of its muscles, and adds no little to the distressing paroxysms of dyspnœa so common in the latter stage of this disease.

In fatal cases death usually occurs in five or six days; in those of unusual severity, however, life may terminate as early as the second or third day.

The mode of death is of course, at least in the majority of instances, by asphyxia; a few die seemingly from pure exhaustion. In some, death is peaceful and quiet; in others life goes out during the throes of a violent convulsion. Unless a comatose condition should supervene, which rarely occurs, the intellect generally is clear to the last.

As this is a disease of almost unparalled fatality it is of the utmost importance that a correct diagnosis be made in the very beginning, as everything, so far as a successful result is concerned, depends upon *early* treatment. The affection for which, perhaps, more than any other it is most frequently mistaken is spasmodic laryngitis, sometimes called catarrhal or false croup. While in some particulars the two diseases simulate each other very much, it will be found that there are diagnostic symptoms in one which are not present in the other, and, which carefully observed, will almost invariably lead to a correct differential diagnosis.

The one is rather gradual in its inception, with symptoms not unlike those in a common cold, but steadily increasing in severity; the other commences, as a rule, in the night, abruptly, generally without any premonitory symptoms, followed very soon by a rapid improvement. In the one the cough, generally very troublesome, is eminently *croupal*, that is, *dry and hoarse;* a cough which it is difficult to describe in words, but which once heard is not likely to be forgotten. In the other the cough is not nearly so frequent and is wanting in that singularly dry, harsh, ringing sound so characteristic of the former. In the one, on inspection of the throat, in almost every case you will discover low down in the fauces the pseudo-membrane, also fragments of this, sooner or later, may be seen in the sputum.

Croup is sometimes confounded with internal convulsions or laryngismus stridulus. This mistake ought not to be made, for it seems to me there is scarcely any symptom in common in the two diseases. This latter is a wholly nervous affection, and while there may be and is at times, great difficulty in breathing, it is attended with no fever; there is no hoarseness of the voice and no croupal cough. In what I have had to say thus far, particularly in that part of this paper which relates to the clinical history and diagnostic features of croup, I have relied mainly on facts obtained by actual observation and personal experience. For in the past few years I have had under medical management at least my share of cases belonging to this disease, and the great fatality attending their treatment has caused me no little mortification and brought up reflections that were painfully unpleasant.

In this connection I would refer briefly to the theory advocated

by some, of the *identity* of true croup and diphtheria. This to me seems to be strange conclusion, totally unsupported by clinical facts, and I believe by pathological also. Several years since, while practising medicine in the eastern part of the county, diphtheria prevailed as an epidemic in the neighborhood in which I lived. The affected district embraced an area about two miles wide and three miles long, was elevated and rolling, lying in close proximity to a small running stream, and for years had been comparatively free from sickness of all kinds. The disease broke out about the first of October and continued to prevail until the following February. During its prevalence I treated, alone and jointly, quite a large number of cases. I saw cases representing every phase and character of the disease, from the most malignant down to the mildest grade possible. Except in the very old, no age, sex or condition seemed to be wholly exempt from it. All ages, from the infant of two months to the strong man of fifty years, were numbered among its victims. The vast majority of those attacked however were children probably between two and ten years of age.

Different cases presented different and varied symptoms. In some the first evidence of illness was manifested in a severe and violent chill; this, during the exacerbation of fever, was not unfrequently followed, in children, by convulsions. In others the first symptoms were apparently insignificant and trifling, the patient complaining for two, three or four days of chilliness, headache, slight fever with impaired appetite, but was still able to be up and walk about. But in all cases, however severe or mild, an examination of the throat would reveal more or less redness, swelling and inflammation of the fauces; and if the case had been ailing a day or two there would be found usually on the tonsils, first the characteristic diphtheritic exudation, and if the attack was a mild one the pseudo-membrane would frequently confine itself to these glands. In those of a severe type the entire pharynx up to the velum palati and down as far as the eye could view, would be lined with it; while in cases representing the severest grade of the disease, it invaded the posterior and anterior nares, covered the uvula, soft palate, inside of the cheeks, lips and gums. Exceptionally the larynx and trachea were involved in

the exudative process, and of course we then had superadded the usual croupal phenomena. There was in every case swelling of the lymphatic glands of the neck, nearly always, it appeared, proportionate to the intensity of the attack.

In some instances the glandular enlargement was enormous, involving the chain of glands anteriorly, from the base of one ear to the other. The swelling from first to last was characterized by a stony hardness, was generally sensitive to the touch, and in no case was it followed by suppuration. In severe cases there were symptoms not unlike those in mercurial ptyalism; the saliva, fœtid and acrid, pouring from the mouth in almost a continual stream. From the anterior nares, also, there issued a foul burning discharge, which, in its passage over the lips, would inflame and blister as if by fire. Quickly upon the swollen lips there appear, in many instances, the characteristic exudation. Frequently there was hæmorrhage, not always slight, but sometimes profuse and alarming. The seat of the hæmorrhage was sometimes as extensive as the diphtheritic inflammation, however wide spread that might be. In some of the most malignant cases, there was a peculiar, sickening, nauseous odor of the breath which was almost intolerable. In one or two belonging to this latter class, there was gangrene of the fauces. At one time I picked from the throat of an interesting and intelligent young lady, one among the first cases, both tonsils entire, the whole of the soft palate, with its anterior and posterior arches, and a considerable portion of the contiguous muscular tissue.

Deglutition was always difficult and painful, and sometimes absolutely impossible. It was not uncommon for cases to pass two or three days in succession, totally unable to swallow a teaspoonful of the blandest fluid. A not uncommon symptom was an excruciating pain in one or both ears. Cough was not a prominent symptom, neither in severe or mild cases, excepting in those where there was an involvement of the larynx or trachea, which, as already observed, did not often occur.

The duration of the disease, in fatal cases, varied widely. One bright little girl of four years died in thirty-six hours from the time she first began to complain. In this case the local lesions were comparatively insignificant, death resulting, apparently,

from the action of some powerful, general depressant or poison. Some lingered for two or three weeks, and died from asthenia, while there were others still who, after struggling through all the different stages of the disease, with every prospect of an early restoration to health, paralysis of the pharyngeal and palatine muscles supervening, died at last of starvation. Some, after having been convalescing for weeks, were still pale, cachectic and feeble, looking as if they had just passed from the hands of some blighting pestilence—and they had. I just referred to paralysis in connection with the disease. This occurred as a sequel, and, I think, only in the severe cases, and in no instance until after the establishment of convalescence. As to the time of its appearance, and the different parts of the body affected, there was no uniformity or regularity, and in regard to its duration and results, every principle of nervous pathology seemed to be violated.

In some the paralysis was limited to the pharyngeal muscles; in others the palate alone was affected. Some were paralyzed in one arm; another in the leg. One had paraplegia, two hemiplegia. Several had facial paralysis, affecting one side only. Strabismus was not uncommon. One patient had converging strabismus in one eye, and diverging in the other. I think, as a rule, the paralysis was confined to the motor system of nerves, special and general sensibility, apparently, being but little impaired, though this was a point it was difficult, in some cases, to decide. Excepting in one or two quite young children, in whom the pharynx and palate were paralyzed, rendering deglutition impossible, death resulting from inanition, every case of which I had any knowledge recovered perfectly from the paralysis in periods ranging from three to eight weeks. I did not examine the urine for albumen, but have quite recently had under treatment several severe cases of the disease, where I examined urine and found it present in considerable quantity.

I trust I will be pardoned for this seeming digression, and for the time consumed in enumerating some facts I have learned while at the bedside of those suffering with this frightful malady. I have tried to give some of the clinical and diagnostic facts relating to diphtheria, as they actually occurred, in contra-dis-

tinction to those of true croup, which some eminent pathologists claim is identical with diphtheria. While I am not prepared to prove the non-identity or duality of the two diseases, I am no less prepared to accept the theory of their oneness or unity.

All who have had any considerable experience in the treatment of true croup, and have watched its progress and its results, will, I think, concur in the conclusion that it is one of the most dangerous diseases of childhood ; indeed, called upon to give a prognosis in any given case, if I should be governed by my own past unhappy experience, it would almost necessarily be unfavorable.

Dr. Ware, of Boston, high authority in this disease, says ninety-five per cent. of the cases of true croup prove fatal. Out of every one hundred attacked, only five recover ! This is, indeed, a fearful mortality, but, notwithstanding this unfavorable showing, I incline to the belief that many cases that die would get well, could judicious treatment be instituted at the *proper time*. The disease is a deceptive one. In the midst of violent and threatening symptoms there is often a rapid change, apparently, for the better. The child becomes quiet, the distressing dyspnœa in a measure subsides, and the little patient, if old enough, may insist on getting on its feet and running about the room. This amelioration in the symptoms is supposed to be due to the detachment of the exudation. Unfortunately, in the vast majority of cases, the improvement is of short duration. After the lapse of a few hours the membrane is reformed, the child grows rapidly worse, and is very soon relieved by death.

We should, therefore, be careful and not deceive ourselves ; nor should we encourage the hopes of friends, when we have reason to know that these hopes are delusive, and are soon doomed to disappointment. To do so is always a cruel wrong, and not unfrequently results in the forfeiture of that confidence and respect which we might otherwise command. A favorable result may be looked for, if, along with an amelioration of the threatening symptoms, the cough should become loose and the expectoration free. In those that recover, convalescence is usually slow and protracted.

In the treatment of this disease, the profession is forced to

acknowledge the humiliating truth that they are comparatively powerless. As the presence of the false membrane is the chief source of danger, an important point to decide is, can its formation be prevented? Is there any method of treatment, however early commenced and faithfully carried out, that will prevent the fibrous exudation? Does the exudation depend upon the active character and violence of the inflammation? The history of the disease, together with the results of treatment, as given by competent observers, would certainly give a negative answer to these interrogatories. I think it may be possible, if the case can be seen in the very beginning, by judicious management, to limit the *quantity* of the deposit on any given surface, and, it may be, also the *extent* of the inflamed mucous membrane; but we are confronted with the fact that, in the majority of cases, the physician is not called soon enough to accomplish ends so important and desirable. As a rule, long before medical aid is solicited the pseudo-membrane is fully formed, and is gradually and certainly moving forward in its work of death. Is there any remedy which, applied topically, will dissolve or remove the exudation? Not as yet known.

Bearing in mind then, that the false membrane is already present, on which depends the principal danger; that if life is prolonged a few days it will be loosened and thrown off by the suppurative process which is sure to take place, the indications are plain.

Heroic measures, such as blood letting and the administration of powerful sedatives, should not, in my opinion, be resorted to. The patient's strength ought rather be husbanded for the approaching conflict, by appropriate nourishment, and, it may be, the use of alcoholic stimulants, and such therapeutic means adopted and persisted in as may relieve the engorged condition of the inflamed mucous membrane, remove the submucous œdema, promote expectoration and assist in the detachment of the false membrane. In the effort to accomplish at least some of these results, emetics are, perhaps, more largely employed than any other class of remedies.

There is no question, I think, but what, in many cases, they are productive of good, but their use may be most frightfully

abused. They undoubtedly play a very important part in controling the nervous element of the disease; they promote expectoration, and they have something to do, in the later stage of the affection, in the separation and expulsion of the exudation.

This latter happy effect of an emetic was strikingly manifested in a case of mine a few years ago. The patient was a boy about five years of age, of a delicate and feeble constitution, and had been an invalid all his life.

He had been sick with croup four or five days, and the case was as unpromising as it could well be. Calling during one of his severe paroxysms of dyspnœa, I was urged by the friends, if possible, to do something more for the little sufferer. As soon as it was practicable, I poured down the throat of my patient a solution of sulphate of zinc. In a very brief period this was followed by free emesis, during which it appeared as if he must die from suffocation; but in the midst of his struggles for life, there was ejected from the mouth, with considerable force, quite a large piece of pseudo-membrane. It was very nearly a complete and perfect tube, was about two inches in length, of a dark or leaden color, soft and friable, and its mucous surface was smeared with pus and mucous. The relief to the patient was instantaneous and well-nigh complete. Convalescence commenced at once and the case recovered. From the long list of emetics some choose one drug and some another. The sulphate of alum is a favorite emetic with many. I have used it often, and can testify to its efficiency. Combined with an equal quantity of ipecac (from one to two grams of each), it rarely fails to provoke vomiting. The sulphate of zinc is frequently used; compound syrup of squill, and even the tartarized antimony, has its advocates. The one, which for several years I have relied on more than any other, is the sulphate of copper. Its chief recommendations are the smallness of the dose, the prompt manner in which it acts, and the almost complete absence of any depressing effect. To a child from three to five years old, may be given 0.07 or 0.15 grams dissolved in water, and repeated, if necessary, in fifteen minutes. Turpeth mineral is also highly extolled by some. I have never used it, and have therefore no experience to give.

Calomel, with many eminent physicians, is a remedy of high

repute in this disease. I have but little faith in the correctness of the theory entertained by some, viz: that its employment in croup, by some peculiar effect upon the blood, prevents the formation of the exudations. It is more reasonable to conclude that the good results which some claim for it, are due to the *thinning* effect it may have on the thickened mucous membrane and the removal of the sub-mucous infiltration. I have used it in many cases, in small doses frequently repeated, and in large ones at longer intervals and have tried to watch and study its effects, but cannot say that I am prepared to speak absolutely in its favor. Inasmuch, however, as it has many strong friends and able advocates, it would be well to give it a trial. To a child four or five years of age, I would give as much as 0.15 grams, combined or not, with Dover powder, every two or three hours, continued for two or three days.

Chloride potash is largely used by many, combined with muriate of ammonia, it is a favorite remedy of Dr. J. Lewis Smith. In the treatment of this affection, I consider it an agent of great value, and inasmuch as it is a solvent of fibrin, it meets indications perhaps met by no other drug. While we may not be able to make a topical application of the remedy to the affected surface, it should be remembered that, taken internally, it is eliminated in the secretions and excretions, hence, in this way, it may come in direct contact with every part of the false membrane. I usually make a saturated solution and give it, combined with simple syrup, in teaspoonful doses, for several days in succession if all goes well.

Local treatment is, in many cases, attended with flattering results; indeed, in the management of croup, many rely mainly on this method of treatment. Of the remedies used topically, nitrate of silver has many champions; a solution varying in strength from four to six per cent. may be applied to the pharynx several times in the twenty-four hours, if thought necessary.

Some advise the introduction of the probang into the larynx, a feat which I would not recommend, and one which, I think, is rarely successfully performed. Among other local substances, now largely used by many, may be mentioned the liquor of the subsulphate of iron, bromine, and carbolic acid. With these I

have had no experience. In this connection I would refer specially to the inhalation of steam as a measure of great value. I have employed it in a number of cases, in some of which, at least, I can speak with confidence of its happy effects. A few years since a member of my own family, a boy six years of age, was attacked with croup in its secondary form, The disease occurred in the declining stage of measles. The child had naturally a fair constitution, but his system had been considerably weakened and reduced by the primary disease.

The croupal symptoms soon became marked and threatening, great dyspnœa and a total extinction of the voice rapidly following on the first appearance of the disease. Every feature in the case seemed dark and gloomy, and death appeared imminent and near at hand. Deciding to try the effect of steam, he was taken into a rather small room, and the necessary preparations made as rapidly as possible. These consisted in simply heating several flat rocks and bricks, and placing them in large shallow pans containing a little water. In this way steam was rapidly generated, and very soon I was overjoyed to notice a change for the better. The steaming process was kept up without intermission for at least twenty-four hours, when—the child all this time comparatively comfortable—it was intermitted. In a very brief period the cough became dry and the breathing labored, and the case was evidently again losing ground. The steaming was resumed and continued incessantly for seventy-two hours, when it was gradually withdrawn. From this time there was a slow and steady improvement, which continued until his health was fully restored. It might be proper to add that the aphonia continued for five weeks.

Throughout the treatment the temperature of the room was maintained at 27° to 32° C., and the atmosphere within literally steeped in moisture. As to the external treatment of the neck but little need be said. Some prefer poultices; some recommend the use of iced water; while there are others who blister. Poultices and warm water dressings are, in some respects, superior to all other applications, and I generally give them the preference.

One word more and I will close the already too long and

imperfect paper. Failing to relieve one patient by therapeutic measures, the question of the propriety of tracheotomy may come up for our decision. As to whether the operation does or does not save life in this disease, the opinions of the medical world are divided. Some eminent practitioners advise and practice it; others condemn it in the strongest terms. If the published statistics in regard to tracheotomy in croup are reliable, certainly many cases operated upon get well, whether *because* of the operation or in *spite* of it may be a question difficult to settle. My own humble opinion is, that the operation, *timely* resorted to, *may*, in rare cases, save life.

Since the days of Bretonneau and Trousseau, it has been practiced quite largely in Great Britain and France, rather sparingly in the United States, though at present the propriety of the operation seems to be growing in favor with the profession of our own country.

ARTICLE IV.

ON SOME OF THE UNUSUAL EFFECTS OF ATROPINE, AND THE MEANS TO COUNTERACT THEM.

By F. C. HOTZ, M.D. (Read before the Chicago Medical Society, Dec. 2, 1878.)

The form in which atropine is generally used in ophthalmic practice, is a watery solution of sulphate of atropia (0.1 in 25.0 grams). A drop of this solution put upon the conjunctival surface of the lower lid causes no pain, and no more irritation than a drop of pure water. As a rule, it has this pleasant effect upon healthy eyes as well as upon those affected with the inflammations for which the use of atropine is indicated.

This rule, however, applies only to the use of pure sulphate of atropia, which makes a clear, colorless, neutral solution, without any sediment. The presence of free acid, sediments, or any other impurity, manifests itself quickly by an unpleasant effect upon the eye. And as it occasionally happens that an inferior article is dispensed by druggists, it may be well to know that the eye is an exceedingly sensitive test-object for the chemical purity

of atropine, and that by its reaction we may sometimes prove a solution to be adulterated which in appearance seems to be quite the reverse.

In August I prescribed atropine to a young lady for acute ulcerative keratitis. Two days afterward, when she called again, I was surprised to find the pupil undilated, although the iris was not implicated in the morbid process, and the corneal inflammation of such a degree that I expected a quick and complete mydriasis. As patients and their attendants are often exceedingly awkward in the manipulation of eye-drops, I attributed the absence of mydriasis to a failure on the part of the patient in applying the medicine. I instilled a drop of a one per cent. solution I kept at my office, in order to show her how it should be applied. The pupil readily responded to my atropine, and was completely dilated when the patient left the office. Still again, after two days, she came with her eye unimproved and the pupil undilated; but she assured me that the drops had been used regularly, and that she was sure they had reached her eye; she said she could feel them, for every time the drop was put in her eye, it smarted for about fifteen minutes. This statement was sufficient evidence that the medicine had been applied properly, and if it had not the desired effect, the failure could not have resulted from insufficient use, but was from an abnormal action of the medicine itself. And it remained to be determined whether this anomalous effect was produced by an impure solution or by a peculiar intolerance of atropine on the part of the eye. The solution the lady showed me was clear, colorless, free of acid and sediment, had the characteristic taste of atropine; in short, it seemed to differ in no way from my solution, which I knew to be perfectly pure and trustworthy. But when I put a drop of my solution in the lady's eye, it did not cause any smarting, the pupil soon began to dilate, and under the continued use of my solution the pupil remained dilated, and the eye quickly recovered. This experiment showed that there was something wrong with the other solution. For if the smarting it produced had been due to an intolerance of atropine on the part of the eye, the same unpleasant effect would have succeeded the instillation of my solution; but if the solution of known

purity acted normally in every respect, while the other produced abnormal symptoms, we must logically infer that these symptoms were due to an adulteration of the atropine in the second solution.

I relate this instance because it may show that in cases in which we believe we have had an anomalous local effect of atropine, we must always ascertain whether the atropine employed was pure. An impure alkaloid will always act as an irritant upon the eye, while the pure atropine sulphate does so in very exceptional cases.

But occasionally we meet with patients upon whom the use of the purest alkaloid has a peculiar effect, altogether different from that which we are accustomed to observe. In all these cases, I believe, there exists a peculiar susceptibility of the patients, which manifests itself by an unusual, local or constitutional effect, of the drug.

The local idiosyncrasy—if I may use this phrase—is characterized by a sense of smarting and heat in the eye, accompanied by redness of the conjunctiva and an increased secretion of tears the first and every subsequent time atropine is dropped in the eye. These symptoms may pass off in a few minutes, or they may last a few hours.

As an illustration of this kind of unusual effect of atropine, I will cite the following observation.

In May, 1877, a gentleman consulted me in regard to an increasing dimness of his left eye. The pupil was very small, and to dilate it for the purpose of an ophthalmoscopic examination, I instilled a drop of my atropine solution. As it had acted very pleasantly on all previous occasions, I was surprised to hear this patient complain of considerable smarting after the atropine was dropped in the eye. The pain was so great that the patient had to keep his eye shut for a few minutes, and when he was able to open it again, the conjunctiva was very red, and the tears ran over the lower lid freely. But the pupil became fully dilated in due time, and I could ascertain that the fundus of the eye was normal, and the impairment of vision was caused by a slight central cloudiness of the crystalline lens. At that time it did not occur to me that there was any relation between the peculiar

symptoms which followed the use of atropine, and the drug itself, but I regarded their occurrence as merely incidental. But in August the patient came back for a second examination, and the use of atropine produced the same smarting and redness in the eye as I observed on the first occasion. And then it struck me that between the atropine and these symptoms there was a relation of cause and effect, and that this eye was unusually intolerant of the solution.

But the most remarkable instances of atropine idiosyncrasy are those cases in which a single drop of atropine put in the eye produces characteristic symptoms of constitutional disturbance. A short time after the application of atropine (which may or may not cause a slight smarting in the eye), the patient is taken with palpitation of the heart, precordial anxiety, headache, dryness of the throat, and restlessness which is considerably aggravated by a burning and intolerable itching all over his body. The face then becomes flushed, as if the patient had been standing over a hot stove, or was in the fever heat of intense excitement. This redness swiftly extends from the face to the neck, arms and over the other parts of the body, so that in half an hour the patient looks as if he had scarlet fever. These symptoms subside in the course of a few hours; sometimes desquamation of the epidermis succeeds this scarlatinous eruption.

Cases of this unusual susceptibility for atropine have been frequently observed in ophthalmic and other practice. So we find in Ziemssen's Cyclopædia, vol. xvii, p. 667, the following instances: "J. G. Wilson (*Glasgow Med. Journal*, Feb., 1872) saw two cases in lying-in women who had belladonna ointment rubbed on their breasts to produce galactostasia, and upon whom a scarlet eruption came out, which lasted three or four days. Stadler (*Med. Times and Gaz.*, April, 1868) saw a similar eruption appear upon a child three months old, within a few minutes after the administration of $\frac{1}{210}$ grain (0,0003) of atropine sulphate for whooping cough. It lasted five hours."

If similar cases are oftener observed by ophthalmic surgeons than by practitioners, it is because they use atropine so much more frequently. The symptoms of intoxication are the same

whether the alkaloid is given internally or applied externally; but it is interesting to consider the infinite smallness of the dose which is sufficient for the production of a toxic effect in those cases. One drop of a half per cent. solution contains about 0.0003 ($\frac{1}{240}$ grain) of atropine; but it is safe to assume that at least one half of this drop is washed out by the tears and runs over the lower lid; and only 0.00015 ($\frac{1}{480}$ grain) remains to be absorbed by the cornea and conjunctiva, and taken up into the blood causes the constitutional disturbance.

It is the unanimous opinion of all writers that when a patient exhibits symptoms of idiosyncrasy, the further use of atropine should be dispensed with. Under circumstances, however, this advice may place the attending physician in a very embarrassing position; for instance, if he has to treat a case of acute iritis. If he does not use atropine (and he cannot obtain any other reliable mydriatic) the pupil remains contracted, and probably will be occluded by circular synechiæ; if he does use it, his patient will be in a state of continuous intoxication. Should he suffer the eye to be permanently damaged, or subject the patient to the annoyance and danger of atropine poisoning? This is a serious dilemma; and the only satisfactory solution seems to me is to find some remedy which possesses the property of counteracting the unpleasant effects attending the use of atropine, without interfering with its valuable local influence upon the eye.

The antagonism of action of atropine and morphine is a well established fact and has been utilized by many in counteracting the nauseating effect hypodermic injections of morphine produce in many patients, by adding to the morphine solution a small amount of atropine. It has also been proven, in a number of instances, by the antidotal effect hypodermic injections of morphine had in poisoning by atropine and vice versa. And the hypodermic use of morphine was also recommended by Graefe and others to counteract the constitutional effect sometimes produced by the local use of atropine. These considerations led me to try whether the unpleasant constitutional effect of atropine could not be neutralized or altogether obviated by adding a little morphine to the atropine solution intended for local use. During last summer I tried this

experiment in the following case, which exhibited the typical signs of idiosyncrasy after each instillation of atropine.

Acute Ulcerative Keratitis; Atropine Idiosyncracy Relieved by Morphine.

Mrs. C. S., aged 39 years, of a very nervous temperament, has repeatedly suffered from inflammations of her eyes. Thirteen years ago the right eye was the seat of a protracted and painful inflammation, which permanently impaired its sight. In March, 1873, I treated her left eye for marginal keratitis. She had several slight attacks since, but the eye always recovered in a few days. In June last, both eyes became very red and extremely painful. The patient, encouraged by previous experience, expected to get over this attack just as quickly; but after patiently waiting in vain three weeks for the change, she at last concluded to seek medical advice. I saw the lady on June 26, and found her very nervous and worried, particularly about her left eye which, she feared, would become as blind as her right one. There was a copious secretion of tears, marked intolerance of light, and great supra-orbital neuralgia. The eye-balls were tender to pressure, and showed a broad zone of pericorneal injection; in the left cornea, near the upper margin, a small, longitudinal, superficial ulcer; in the right cornea an old central cloudiness of the epithelium, but no new infiltration. The pupils were contracted, but dilated readily and regularly in the dark. I prescribed a half per cent. solution of sulphate of atropia, to be instilled into each eye three times daily; and a saline cathartic.

At my visit on the next day I found the eyes better and the pupils fully and regularly dilated; the patient had no pain, but she said that fifteen minutes after each application of the drops she had felt a great uneasiness, with palpitation of the heart, dryness of throat, a burning and itching sensation all over her body, and, soon after, her face and whole body were as red as if she had the scarlet fever. This lasted about one hour; then the integument recovered its natural color and the patient felt quite well.

The next day the patient gave the same report, and I could convince myself of the correctness of her observation. I instilled

with the dropping tube one small drop of the atropine solution into the left eye, and had her keep the eye closed for a few minutes, while I was pressing upon the lachrymal sac. In fifteen minutes by the watch the acceleration of the heart's action manifested itself in the quickened pulse; the patient felt oppressed, as though she would suffocate; had that burning and intolerable prickling of the skin; her face became scarlet, and this redness swiftly extended over neck, hands and arms.

This observation left no doubt that these symptoms were the constitutional effect of the minute dose of atropine administered, and that the medicine had to be discontinued unless its constitutional effect could be prevented. I disliked the idea of abandoning the use of atropine, and it occurred to me to try whether the antagonism of morphine and atropine could not be utilized in this case. And in order to make the experiment conclusive, I had the same solution of atropia continued, but added to it 5 centigrams of morphiæ sulphas. The patient used this combination without any discomfort; those annoying constitutional disturbances did not once re-appear, and the eyes got well.

But in September the patient had a relapse of keratitis in the left eye. For the sake of testing her idiosyncracy again, I put one drop of a pure one-half per cent. solution of atropine into the eye. It had precisely the same effect as in June; and again, the addition of morphine arrested the constitutional effect, without interfering in the least with the local action of the atropine upon the iris.

It will be noticed that in the above described case the constitutional symptoms occurred even when I employed these precautionary measures which prevent the entrance of atropine into the tear passages and the pharynx, whence it is more rapidly absorbed than in the eye. Sometimes the constitutional effect can be obviated by pressing upon the lachrymal sac with the finger during and a little while after the instillation of atropine.

This measure is especially successful in those cases in which the absorption of such minute doses of atropine produces no other sign of poisoning than dryness in the throat. One of my patients, who was greatly annoyed by this dry feeling in the pharynx, operated in the following manner: When he put

atropine in his right eye, he laid down and turned his head to the right, so that the tears would flow toward the external canthus, as the lowest part of the conjunctival sac. By thus reversing the tear current for a minute, the atropine which was not absorbed by the eye was washed out by the tears, and none got into the throat.

Under circumstances, the entrance of atropine into the pharynx produces more distressing symptoms than dryness of the throat. All along its passage over mucous membranes the atropine is eagerly absorbed, and although each drop contains but a very minute dose, a sufficient amount may gradually accumulate in the blood to produce marked toxic symptoms. Children have shown signs of poisoning after a few instillations of the half per cent. solutions; and in adults similar accidents have occurred if stronger solutions were used, and especially if the applications were made in short intervals. I remember very well a case which occurred in my practice some four years ago, and I will give a brief report of it from notes kindly furnished by Dr. W. T. Montgomery.

Case of Poisoning from Local Use of Solution of Atropia.

In March, 1874, Mr. A. K., aged 72 years, in good general health, had cataract extracted from each eye, Dr. Hotz performing the operations. The day after extraction, the wounds were found closed, and a solution of atropia sulphate, 0.1 to 40., was ordered to be dropped into the eyes three or four times daily. On the third day slight iritis was noticed, when a solution of 0.2 to 40. was ordered to be dropped into the eyes once in two hours. The day following this the patient began to be delirious, and to the delirium was soon added all manner of absurd hallucinations, so that the attendant became alarmed, and thought the patient was coming down with fever or some other grave disease. The pulse was found rapid and feeble, skin flushed and dry, tongue dry and brown, great thirst and dryness of throat. The temperature was taken and found to be normal. This fact, of course, excluded the question of fever or severe inflammatory trouble. The next thought was that the old gentlemen had gone crazy.

The following night the delirium and hallucinations continued, so that the patient had to be restrained to keep him in bed and from tearing the bandage from his eyes. It had occurred to the attendant that the symptoms were those of belladonna poisoning, and when the local use of atropine was discontinued, and morphine was given internally in liberal doses, the patient quickly recovered.

In concluding these observations, I wish to repeat that these and other anomalous effects of atropine occur comparatively very seldom if we consider the frequent use of this alkaloid in ophthalmic practice. And while it is certainly very well for us to know that these incidents happen occasionally, and to remember the means by which to obviate or counteract them; they should not discourage us in the least from using atropine wherever its employment is indicated. For we must never forget that these exceptional results are outweighed a hundred fold, nay a thousand fold, by the good service atropine has done and always will do to people afflicted with diseases of the eye.

GLYCERIN OF THE OXIDE OF ZINC. F. Pollet.

Glycerine	16
Starch	8
Oxide of Zinc	1

Mix.

For the dressing of rhagades and chronic inflammation of the anus. Rhagades, which are little fissured ulcerations, situated in the natural folds of the anus, or frequently at the base of, or in the angle formed by mucous patches, vegetations or condylomata, often yield to simple cleanliness, to dressings with aromatic wine, or light cauterizations with nitrate of silver. It is when they are rebellious to these means that recourse is had to the glycerine of zinc. In point of fact, in order to obtain a definitive cure, it is first of all necessary to dissipate the lesions which give rise to the rhagades, and of which they are only a complication.—*L'Union Médicale.*

Clinical Reports.

ARTICLE V.

MERCY HOSPITAL.

REPORTED BY F. E. WAXHAM, M.D.

CASE I—*Stricture of Urethra.*

The patient entered the hospital Nov. 2d, with a very tight stricture. This had existed for twelve years. In 1862 he had an attack of gonorrhœa followed by gleet. Has had complete retention of urine several times, and was relieved only by tapping the bladder above the pubis. On entering the hospital, the stricture was so tight that nothing could be passed through it, although a No. 1 instrument entered a short distance. From day to day the attempt was repeated to pass the stricture, but unsuccessfully. On Nov. 6th complete retention occurred. After many trials and a great deal of patient labor, a very small filiform bougie was passed through the stricture into the bladder. This dilated his urethra so that he was able to pass water. Shortly after, he suffered a very severe urethral chill, followed not by fever but by a very copious perspiration.

Nov. 8th, complete retention again occurred. Patient suffered greatly from spasmodic contraction of the bladder. The pain and spasm were controlled by opiates and monobromated camphor, the latter in two decigram doses repeated every hour. Under this treatment he soon slept soundly, and passed his urine involuntarily while in this condition.

Nov. 11th. Anæsthetized, and internal urethrotomy performed by anterior and lateral incisions. A very small filiform bougie was first passed by the stricture and the free extremity attached to a staff, the former instrument curling up in the bladder and acting as a guide to the staff which followed it. The urethre-

tome was then passed down the groove in the staff, first anteriorly and then laterally, thus severing the stricture. A No. 10 sound was introduced into the bladder, followed by a No. 12 and No. 16. Shortly after the operation the patient suffered a very severe urethral chill. His temperature fell to 95½. He, however, had no repetition of these symptoms, and was discharged, cured, Nov. 20th, able to pass a full stream of water.

CASE II—*Stricture of Urethra with Perineal Fistula.*

Stephen Wright. Age 55. Entered the hospital with the following history: About five years since, while carrying a heavy weight on his shoulder, he fell across a well-curb, injuring his perineum very severely. He has suffered from gradually contracting stricture since that time. Last summer he was able to pass his water only drop by drop. In July infiltration of urine into the perineum and scrotum occurred. This being mistaken for erysipelas, a great amount of sloughing of perineum and scrotum took place before free incisions were made. The damage has gradually been repaired, but a small urinary fistula has been the result.

Nov. 11th. As it was impossible to cure the fistula as long as the stricture existed, urethrotomy was performed, as in the former case. A few hours after the operation this patient also suffered a very severe urethral chill.

Dec. 20th. Stricture has yielded completely, and fistula nearly healed; general health excellent.

CASE III—*Artificial Anus.*

Mrs. C.— Age 35. A year and a half ago the patient suffered from a strangulated inguinal hernia. Dr. Andrews being called five days after the strangulation occurred, found her in a very feeble condition. Although little hope of saving her life was entertained, she was operated upon, and six inches of dead intestine were removed. The healthy edges of the intestine were stitched to the opening, making an artificial anus. The patient made a gradual recovery.

On entering the hospital last April, she was pale and very anæmic. Nearly all the passages from the bowels were through the

artificial opening. Occasionally a very small passage would occur through the natural canal, showing that the lower portions of the bowels were still patulous. The first operation consisted in placing a clamp upon the septum of the intestine at the opening, thus removing it by gradual suppuration. Several operations were performed for the closure of the opening, each time freshening the edges of the wound and bringing them together by silver wire sutures, tightened by preforated shot or a lead button. This patient returned home in August with the opening nearly closed, it being no larger than a crow's quill. The patient returned Oct. 30th to have this small opening closed although there was but very little discharge from it.

Nov. 11th. The edges of the opening were pared off and incisions were made through the integument and cellular tissue about an inch from the wound on each side, that the freshened surfaces might be approximated. An opening was also made from the lower incision under the integument and areolar tissue to the opening in the intestinal canal, and a drainage tube inserted in order to give the old opening a better opportunity to heal. The freshened edges of the opening were then brought together by silver sutures. The operation proved successful.

Dec. 9th. Again anæsthetized and the whole surface of the old cicatrix removed and a flap two inches square taken from below on the thigh and layed over this. The edges were united by sutures all around, excepting on one side, where an opening was left communicating with the intestine. A drainage tube was inserted in this opening under the flap.

Dec. 14th. Patient suffered severely for several days, but at present date is doing well.

CASE IV—*Enlargement of Prostate.*

Peter Peterson. Age 59. Entered the hospital Nov. 7th, with the following history: He had always been healthy until a year and a half ago, when profuse hæmorrhage occurred from the urethra, lasting two days and prostrating him very much. Hæmorrhage recurred once or twice between that time and June 17th, 1878, at which date he bled until death seemed at hand. He has had increasing frequency of micturition until the present time,

when he frequently can not retain his urine longer than ten minutes.

Nov. 9th. Made an incomplete examination for stone. Found the prostate much enlarged, forming a tumor which nearly occluded the rectum.

Nov. 11th, the patient was anæsthetized and a thorough examination made. No calculus was discovered. The bladder was found contracted and its walls thick and grisly. The prostate was enormously enlarged, but it was thought to be probably a simple enlargement without possessing any malignant characters.

Nov. 29th. Left, somewhat improved under the effect of astringent injections.

NOTES FROM PRIVATE PRACTICE.

ARTICLE VI.

Poisoning by Strychnine.

On the morning of May 12, 1878, I was called to see a little girl, aged 9 years, who—as the messenger stated—was having spasms. Supposing it to be a case of convulsions from intestinal irritation, or other ordinary cause, I made no extra preparations, but at once obeyed the summons.

On my arrival I was quite surprised to find myself confronted with a very serious case—such as I had never seen before. By following a proper line of inquiry I was not long in arriving at a diagnosis, which, notwithstanding the protestations of the family to the contrary, was fully confirmed in a few hours by finding an old strychnia bottle with a few grains of the salt yet in it, and which the child afterward admitted she had handled. Any estimate of the amount she took, of course would be conjectural, and I will not give a detailed history of the symptoms. Suffice it to say that for four hours before I saw her, and for nearly ten hours afterward, she was in a continuous and persistent spasm, from head to foot, with an alarming and distressing opisthotonos, rendered all the more painful from the fact that she was entirely conscious of her suffering, while any effort to relieve her by the

slightest touch, or causing her to swallow, only aggravated her condition, by apparently exciting every muscle to increase its tension.

But the treatment adopted is the main object I have in view in reporting the case. I first prescribed .03 of morphia and applied hot water to the spine, but fearing the morphia alone would not be sufficient, I sent back to my office (5 miles) for other remedies, in the meantime continuing the hot water to the spine and, repeating the morphia every half hour. One and a half hours elapsed and, nothing gained, I then gave:

Flu. ex. belladonna..... 2	
Flu. ex. c. indic..... 2	
Morph. sulph.....	03
Elix. simpl.....32	

M. Teaspoonful every hour alternated with the following:

Potassic bromide..... 6	
Hydr. chloral,..... 3	
Elix. simpl.....32	

M. Teaspoonful every hour.

This, though somewhat heroic, as I thought, for a small child, failed to relieve the patient as promptly as I desired, and I had almost despaired of her life, when an expression in one of Brown-Séquard's lectures occurred to me, in which he affirms that "Spasmodic action is due to unrest or a morbid activity of the cells of gray matter in the spinal cord and base of the brain, which results in the destruction of tissue and the exhaustion of nerve force," and he suggests as a remedy, friction, bandaging, or some other force or irritant applied to the extremities.

Acting upon this suggestion—in the midst of a severe convulsion—I grasped her thighs in my hands and used all the force I could in constricting them, when to my surprise and gratification she came promptly out of the spasm, and to some extent was relieved of the muscular stiffness and opisthotonos. To test this more fully, after a few minutes, I relinquished my grasp, and quick as thought she was in another spasm which was just as promptly relieved as before. Convinced of the value of this remedy, I detailed two men to keep up this pressure almost con-

tinuously for about four hours, thus preventing, as I now believe, "the destruction of nerve tissue" and brain force, and the consequent exhaustion of vital energy, until I could get my patient under the influence of powerful anodynes and nerve sedatives, and thus gain time, for I was now persuaded that time, and time only, under such influences, could save her.

To this end I persevered in the treatment—internal and external—alternating doses every 30 minutes, and giving the patient my own personal attention during the entire night.

At 5 a. m. on the 13th, I left my patient, with treatment all suspended, in a profound sleep, from which she awoke in about 6 hours, every way improved, and, save a little twitching of the muscles, at times, and some general muscular soreness, was free from the effect of the poison.

The point of special interest to me in the treatment of the case, was the promptness with which the patient was relieved by the suggestion as indicated in Brown-Sequard's lecture. There is no question in my mind but that it contributed largely to the successful issue of the case.

V. R. BRIDGES, M. D.

ARTICLE VII.

Is the Hypodermic Injection of Piles Dangerous?

About two and one-half years ago I discovered and published in this journal the secret method of the itinerant "pile doctors." The plan of these itinerants, which was sold as a secret, and at a high price from one quack to another, is substantially as follows: a hypodermic syringe, with a very fine, sharp point, is charged with a strong solution of carbolic acid. Generally three parts of crystallized acid to one of any bland oil are employed, but they sometimes combine them in equal parts, and for oil occasionally substitute glycerine. The method of the operation is to insinuate the point of the syringe into one of the piles and throw in a few drops only of the solution. This causes the hæmorrhoid to turn white and gradually to wither away. Another one is then attacked and thus by degrees a complete cure is effected without causing enough irritation at any one time to take the patient

away from business. The operation is sometimes painless, but in other cases decidedly otherwise.

Attention was called to the seeming danger that by this method the carbolized oil might be thrown directly into the dilated hæmorrhoidal veins. The injection of coagulants into venous enlargements of other parts of the body has, in a few cases, caused sudden death by embolism, a portion of the clot being carried to the heart and thence passing into and blocking the pulmonary artery. It was suggested therefore that the injection of hæmorrhoidal veins might involve the same risk. The three groups of hæmorrhoidal veins intercommunicate, but the main outlet of the lower and middle groups is to the internal iliac, and thence to the heart, while that of the upper is to the portal vein. It is conceivable that dislodged clots or globules of the injection might be swept by the current of the blood to the heart, or possibly might press through the upper plexus into the portal vein, and be lodged in the liver.

I learn that a number of the itinerants have taken warning from my suggestion of danger, and employ a sort of clamp forceps, to compress the base of the pile for a few moments at the time of the operation, thus hoping to prevent the passage of clots or globules along the veins.

This method has now been in use over three years, and has been applied to thousands of persons. If there be any actual danger in it, such as is suggested by anatomy, and by the dangers of similar injections in other regions, the results should be manifest before now. Experience only can settle such matters. If on the other hand the plan is safe, it ought at once to be adopted by the regular profession as the best method of dealing with this distressing disease.

To settle this question of danger I take the liberty, through the columns of this journal, of asking every physician in the United States, who has had opportunity to know the results of this treatment, to write me immediately, giving information upon the following points:

1. How extensively has the plan been tried in your region?
2. How far is the plan painless or otherwise?
3. Have any sudden deaths or other alarming symptoms been

known to follow its application, and if so how soon, and what were the symptoms?

4. Have any cases been followed by dangerous disease of the liver?

I propose to collate all the information thus gathered, and communicate the results in a future article through the pages of this journal.

EDMUND ANDREWS, M.D.,
Prof. of Surgery in Chicago Med. College,
No. 6 Sixteenth St., Chicago, Ill.

ARTICLE VIII.

Tincture of Thapsus.

As an efficient remedy for functional derangement of the uropoëtic system, a condition whose organic cause eludes analysis, I have for some time been in the habit of prescribing the tincture of thapsus bursa pastoris, or shepherd's purse, a genus of cruciferous plants. I treat with it not only hæmaturia, for which, on account of its astringent properties, it was formerly used, but cases of renal and cystic derangement very various in their nomenclature; but always this side of any considerable destructive lesion. I desire to draw to it the attention of the profession, because I believe it is a remedy not generally known. It has long been a favorite remedy with the so-called "eclectics," whose leading pharmacist first called my attention to it.

DR. JAMES I. TUCKER.

TREATMENT OF WHOOPING COUGH BY TINCTURE OF MYRRH. By Campardon.)

Whooping cough yields easily and rapidly to the al cohoc tincture (15 drops to the tablespoonful) in quinine wine or Vichy water. A tablespoonful every hour or two. This treatment in no way interferes with the appropriate remedies for the tracheobronchitis or the pulmonary congestion.—*Bull. Thér.*

Society Reports.

ARTICLE IX.

TRANSACTIONS OF THE CHICAGO GYNÆCOLOGICAL SOCIETY.

SECOND MEETING, NOVEMBER 29TH, 1878. W. H. BYFORD, M. D., in the chair.

DR. SAWYER reported a fatal case of puerperal inversion of the uterus (published in the present number of the JOURNAL AND EXAMINER).

DISCUSSION.

DR. MILLER: The subject introduced this evening by Dr. Sawyer, is one of more than ordinary interest to every accoucheur. The report of the case is admirable, and the specimen presented adds greatly to its value. I have no criticism to offer in regard to the management of the case, for it was faultless. The accident happens but seldom. It was fortunate that in this case it occurred under the immediate observation of one so competent to comprehend its gravity from the initial stage, and who could present to us so clearly its complete history.

The causes of inversion of the uterus are various — generally, I believe, mechanical; not always so, however. I can appreciate that inversion may take place as follows: The uterus in a state of complete inertia, from long continued labor, from too sudden delivery of the child, or from over-distension, as in Dr. Sawyer's case, a slight cause may produce depression and end in inversion. That cause may be the increased weight of that portion of the uterus upon which the placenta was developed, if near the fundus, together with the other condition which obtains at the site of placental development, namely, the projection inward of that part of the uterus. The structure of the uterus, immediately surrounding the placental site, in the condition assumed, could

offer no resistance to the further settling internally by gravity of this heavy circumscribed portion of the uterus — depression having occurred, inversion would follow.

Another possible cause of inversion may be mentioned, though not strictly applicable to the case reported this evening. When the uterus is in a state of complete inertia, and the placenta has been detached, and has lodged within the os uteri, the cavity of the uterus, as is usual in such cases, remains large, and is filled with blood. The extraction of the placenta will act as a piston upon the volume of blood in the cavity of the uterus, and this, in turn, will act upon the flaccid wall of the uterus; the fundus may follow this forcible extraction of blood, till depression is produced. Then inversion may be completed by the uterus itself.

I am not certain that attempts at compressing the uterus may not produce a dimpling of the organ that will lead to inversion, especially if performed carelessly, or by a person not familiar with the physiology of uterine contraction. It appears to me that inversion is liable to be caused by the injudicious application of force to the uterus in a state of inertia.

DR. ROLER: The case presented for discussion is an interesting one, but the cause of the inversion cannot be determined, as the attending physician has no knowledge of the exact moment of its occurrence. The delivery of the placenta evidently had nothing to do with the accident, as manipulation immediately afterward detected the outline of the uterus in a flaccid state, the fundus being near the umbilicus. Ergot was administered, and firm pressure applied both over the uterus and upon the abdominal aorta. A little later, when contraction suddenly occurred, the cup-shaped depression was easily recognized by the hand over the abdominal parietes.

The fundal sinking must have taken place before contraction set in, as symmetrical action of all the muscular fibers would insure safety against such an accident. The condition of ergotism may have been the chief cause of failure in the attempted reposition of the uterus, but the administration of the drug was clearly indicated, and Dr. Sawyer did as any intelligent physician would have done under the circumstances.

I fully endorse the remarks of Prof. Miller with reference

to careful manipulation in the removal of the placenta, even after uterine action has thrust it into the vagina. Leishman, J. Matthews, Duncan, and others, state that if left alone it usually presents edgewise during expulsion, but I think the bedside experience of every physician proves that without meddlesome interference it is often found fœtal surface foremost, and "impacted" in the vagina. Of late years I have always, when removing it, waited until I found the uterus well contracted above the pubis. It ought to be brought out edgewise and slowly. Traction upon the cord would cause a vacuum above, which would be filled with blood from the open sinuses, or if atony was present, possibly by depression of some part of the uterine wall.

In regard to the forces which operate to bring about complete inversion, I would like to state my doubts as to the ability of the organ, by any contractile power, to invert itself. I am aware that it has become an accepted doctrine that the introverted part may be seized by the remaining portion, and be carried downward, thus completing the process by its own action. I do not think it has been satisfactorily proven by any one who has written on the subject. In what way can any expulsive force be developed when the fundus is not acting? It is a matter of common experience when the uterus fails to contract symmetrically, in any stage of labor, that the expulsive process is arrested. In irregular contractions, even the detached placenta is held in vice-like grasp until artificially removed. If the introverted part contracts, it shortens itself merely. If the encircling portion acts, the further descent must certainly be arrested by the grasp of the circular fibers. Are not the incomplete varieties owing to this fact? When general atony exists, the weight of the descending portion, aided by the straining on the part of the patient, will easily carry the fundus into the vagina.

Irregular contraction is doubtless a primary condition in many cases, of incomplete inversion, the placental area being the paralyzed portion, and sinking downward either from spontaneous or artificial causes. Yet, even in these cases, it can easily be understood how the shock thus produced, together with hæmorrhage, might subsequently cause general relaxation and allow further descent of the fundus.

DR. MERRIMAN was very much interested in the case, which had been reported in so clear and minute a manner. These dangers, although rare, were liable to occur at any time, and there was need to observe as closely as possible all circumstances connected with them, that the causes of the trouble might be more perfectly understood. He did not remember having seen an explanation offered for the first step in the process of inversion, namely, that of depression, except: 1st, the presence of a polypus; 2d, drawing upon an adherent placenta; 3d, pressure from above; but these were evidently not the only causes. Dr. Barnes gives as a circumstance frequently connected with this difficulty, the attachment of the placenta to the fundus uteri. Since the placenta undergoes absolutely no detachment during the strong contractile efforts of the uterus during labor, it seems probable that the placental seat is less affected generally by uterine contraction. If, then, the attachment should be at the fundus uteri, and an unusually relaxed state of the uterus exist, a very little pressure would be sufficient to start a depression which, once started, would readily go on from the contractile efforts of the uterus itself.

He thought of one other explanation. If irregular contractions should occur, they might affect only the external fibers of the uterine fundus, and it would readily be seen that this circumstance would cause the wall of the uterus to bulge inward, thus producing the initial step in the process of inversion. He thought, in this connection, that the effect of ergot, which is so liable to produce irregular contractions of the uterus, should be carefully watched.

DR. NELSON: It has not been my fortune yet to see a case of puerperal inversion of the uterus, but I can readily understand that the piston-like action of the placenta, referred to by Dr. Miller, might be, in a relaxed condition of the uterine walls, a cause of partial or complete inversion, if the cord were drawn upon while the uterus was thus relaxed. For this reason I make it a rule never to attempt to remove the placenta until the uterus is contracting firmly. Then, if gentle traction on the cord, or the presenting portion of the placenta, does not readily extract it, and especially if it seems to be firmly held, while the fœtal sur-

face presenting at the os shows that it is at least partly detached, I bore through the presenting placental mass with the forefinger, to allow the air to pass through the placenta, and thus destroy this sucker-like action, and then the contents of the uterus may be readily removed. But until this is done, or in some way the air allowed to get behind the placenta, traction upon it or the cord will simply drag downward the uterus and its contents until the uterine contractions excited thereby expel the contents. I do not recollect to have seen this procedure described in any of the books, but I have, for several years, found it to greatly facilitate the removal of the placenta.

Dr. Sawyer's exact description of this case suggests also another possible cause of inversion, when the uterine walls are distended and relaxed, namely, pressure upon the uterus through the abdomninal walls by an assistant, especially if unskilled. For I well remember, in assisting Dr. Roler in a footling case, under ether, while pressing firmly upon the fundus of the uterus to hasten the delivery of the head and so save the child, I distinctly felt the walls of the uterus dimple under the pressure, especially when too great force was momentarily exerted by the thumbs and finger points in attempting to relieve the hand, and while the uterus was not firmly contracting. Indeed, the inertia of the uterine walls was the very reason for using these vigorous external means to hasten delivery.

Dr. Sawyer describes the compression of the aorta from the outside, which seems to have been satisfactory in his case; but, if the abdominal walls contain much adipose tissue, it might be more difficult. Following the teachings of my preceptor, Dr. Storer, of Boston, I should prefer to pass the hand directly into the uterus, and compress the aorta through the thin uterine walls. I have not found it difficult to introduce the hand into the uterus immediately after delivery, and the aorta can certainly be as safely compressed in this way upon the spine. Furthermore, the hand itself, in the uterus, will be a powerful means of exciting the uterine contraction, and should any portion of the walls be inverting, it would be in the best possible position to detect and replace it. It is also in position to detach the placenta, if this may have been the cause of the hæmorrhage, or to remove clots

resulting from the hæmorrhage. I have had occasion to compress the aorta in this way but once, and saw no bad results.

As the tetanic contraction of the uterus was described in Dr. Sawyer's case following the use of ergot, the query came to mind, will the use of ether, carried to complete anæsthesia, in such cases, overcome the action of the ergot?

I would also like to ask the members of the society what their experience is in the use of the corn ergot—the fluid extract of ustilago maidis; will it produce, in full doses, these same tetanic contractions which the rye ergot frequently does? I have used the fluid extract of ustilago in my obstetric practice during the past year and a half, using it as I would the rye ergot, in doses of half a teaspoonful and more, and I have not yet seen the severe contractions occasionally produced by the rye ergot; neither is it as liable to disturb the stomach as that—perhaps because the taste is usually not as disagreeable to the patient.

DR. JONES said that he had little to add to what had already been said as to the etiology of inverted uterus.

During the discussion, it had occurred to him that possibly, as in early abortions, a certain balooning of the upper vaginal and lower uterine ligamentous structures might occur after parturition, which would draw apart the inert walls of the womb, and suffer the flaccid fundus and upper segment of the organ to fall into the cavity thus made. Then, under the stimulus of invagination, active contraction, grasping the inverted portion, might be set up, which would tend to complete the "perversion," or render it impossible for the attendant to effect its reinstatement. It was possible that the ergot administered in the case reported might have proved a disadvantage, but that it had anything to do with the causation of the accident, he could not believe. He agreed with other speakers in thinking inversion due mainly to uterine inertia, and that the uterus was not primarily active.

As for the commonly assigned cause—traction upon the funis—he averred his constant practice of that forbidden means of delivering the placenta, but always with the premise of normal uterine contraction. A case of puerperal inversion of the uterus had never occurred in his own practice.

DR. FITCH: I regret exceedingly that I did not arrive in time to hear the opening of this discussion, and the history of the case presented by Dr. Sawyer. My experience in puerperal inversion of the uterus has been very limited; indeed, in an active practice of twenty-seven years a case has never occurred under my own administration.

The only case I ever saw was in consultation. About twenty-two years ago, I was called to see a woman four or five days subsequent to her delivery. I found the patient of light complexion and frame, pale and haggard countenance, pulse 130 to 140, and feeble; skin cold, and covered with a clammy perspiration. Her labor was apparently normal. No excessive hæmorrhage had occurred, and no great degree of pain; yet there was constant vomiting, and great prostration. The physician in attendance had made no diagnosis, but supposed she had "child-bed fever."

I proceeded to make an examination per vaginam. The uterus was low in the pelvic cavity; os open to the size of a silver dollar, and a hard, somewhat roughened convex body presenting, which I at once suspected to be the fundus uteri. I immediately applied firm pressure with two fingers against this body, and counter pressure upon the abdomen, for the space of five minutes; the body gradually receded from the os, and suddenly left my fingers, with a decided thud; at the same instant the uterine tumor appeared in the hypogastria. The vomiting ceased at once; reaction quickly came on, and the patient made a good recovery.

In regard to the influence of ergot in the production of this accident, I believe that its action is upon the entire organ, producing uniform contraction of its muscular walls; therefore cannot favor the accident. My judgment is based on the use of it in probably 75 per cent. of all the cases I have attended during the past twenty years. I believe it is useful in assisting the delivery of the placenta; and further, by producing tonic contraction, it thoroughly empties the uterus, and prevents accumulation of blood in its cavities. For these purposes it is given from 10 to 20 minutes before the completion of the second stage of labor.

I have entertained the opinion that acute puerperal inversion was unnecessary; and that, when it did occur, it was usually due

to neglect in the management of the delivery, or by too active interference.

To avoid this accident, as well as post-partum hæmorrhage, I am in the habit of pursuing the following course: As soon as the child's head is delivered, I direct the nurse, or other convenient person, to apply the hand to the hypogastrium, and follow the receding walls of the abdomen, with pressure directed upward and backward. The person is retained in that position till I have attended to the child, tied and severed the cord. I then place the patient on her back, and apply my free hand to the abdomen, over the uterus, grasping the organ with the thumb and two or three fingers, with the little finger resting on the fundus, for the purpose of promptly detecting any depression or dimpling. If the uterus does not contract promptly, I squeeze it forcibly. As soon as contraction occurs, I apply traction on the cord, equal to a weight of one half lb. to six lbs., at the same time pressing the lateral walls of the uterus, for two purposes: 1st, to assist in the expulsion of the placenta; 2d, to sustain these walls in apposition, and thus prevent inversion. Should dimpling be felt, I at once desist from traction; or should tearing be felt in the cord, traction should cease. I have never torn off a cord or inverted a uterus.

DR. ETHERIDGE remarked that the specimen before the society seemed an unusually large puerperal uterus.

DR. JACKSON had nothing to add to what had already been said in reference to inversion of the uterus. He had never been so unfortunate as to encounter a case in his own practice, and the specimen now before the society was the first he had ever seen. He only desired to express his surprise at the opposing views to which utterance had been given in reference to what should constitute the proper treatment of the third stage of labor, in its bearings upon the causation of the accident in question. One gentleman considered it dangerous to make pressure upon the fundus of the uterus in order to aid the expulsion of the placenta, while another thought this method the best and most favorable. Several regarded traction by the cord as highly dangerous, while others again, on the other hand, habitually delivered by pulling

at the cord, and only limited the strength of the pull by the strength of the cord.

A number were in the habit of administering a dose of ergot to aid the expulsion of the placenta, while another was afraid to give it lest it should not be expelled at all.

Inversion of the womb was usually considered to be a very rare complication of labor; and yet, after listening to this discussion, it seemed wonderful that it was not a very common one. He thought the efficiency of some of the alleged causes was exaggerated. Certainly traction of the cord was. If it ever caused inversion, it must be only in exceptional cases; for he believed that fully 90 per cent. of all placentae were delivered by more or less traction by the funis. His own impression was, that puerperal inversion occurs usually from a passive, inert, relaxed condition of the uterine walls, produced by over-distension, as in the case described by Dr. Sawyer, or from some other causes.

DR. W. H. BYFORD believed that mere atony of the uterus was not a sufficient cause of inversion of the uterus. This condition might be a predisposing cause, and it was probably in this state of the womb that pulling on the cord and other injudicious efforts to deliver the placenta were rightly blamed as causes of inversion. He thought, however, that inversion more frequently resulted from irregular contraction of the uterus, in the sense that some of its fibers were acting strongly, while others were not contracting at all. In other words, there was partial, instead of general atony; one or more patches, limp and flabby, prolapse into some part of the globular arch of the contracting organ, and thus form the dimple so generally supposed to be necessary as a start toward inversion. The vehemence of contraction which this intruding portion would cause, is recognized by most writers as sufficient to complete the displacement. This state of partial atony must occupy fibers partially paralyzed by some circumstance existing during gestation, or occurring at the time of labor.

In the case of Dr. Sawyer, reported with so much intelligence and minuteness, the condition of the uterus anterior to delivery was sufficient to account for a weakened state of the fibers. There was a very considerable dropsy of the chorion, and the

uterus contained an extraordinary amount of liquor amnii. This fact, interpreted, means that the fibers were *stretched.* In normal pregnancy the uterine fibers are not stretched; the whole organ is hypertrophied, and the actual addition of tissue, or growth of the muscles of the uterus, form a receptacle for the ovum that contracts uniformly and with vigor for the expulsion of its contents. Now, if an abnormal amount of fluid is secreted, it is accommodated not by a further increase of the muscular tissue forming the uterine globe, but the organ is *distended*, and the muscular wall becomes thinner by the distension. Thus stretched and thinned, for perhaps weeks before confinement, the fibers become weaker, and the labors succeeding this state of things are precisely the kind described by Dr. Sawyer. The contractions are painful and inefficient, the fibers acting discordantly until the fœtus is expelled or removed, as it was in this case. It is almost certain that the efficiency of some portions of the fibers is more impaired than that of others. It is well known that in uteri thus over-distended we have the hour-glass contraction — the incomplete contraction — accompanied by hæmorrhage, etc., and why not also inversion ?

If the ergot had any injurious influence in the reported case, it was not in causing the inversion, but in rendering the fibers more resistent to efforts at reposition. Dr. Byford further said that the treatment instituted by Dr. Sawyer was such as would suggest itself to most intelligent obstetricians.

It was quite apparent, however, from the tenor of the discussion to-night, as well as the diverse theories of inversion promulgated by writers on obstetrics, that there is yet much to be learned in reference to this most interesting subject.

With reference to the cause of death, he thought there could be no doubt but that it was due to shock, and the hæmorrhage was not sufficient to contribute materially to that end. In expressing this opinion, he would remind the society that the overwhelming influence of shock upon the nervous system depended as much upon the incapacity of certain persons to rally from nervous depression, as upon the force of the causing influence. What would kill some persons would not, on account of the inscrutable elasticity possessed by others, have any effect upon them.

Dr. SAWYER: I feel indebted to the Fellows for the full and very intelligent discussion which my report has elicited, as well as for the very charitable willingness which has been shown to exonerate me from responsibility in the unfortunate termination of the case. The only point which was raised in my mind upon reflection, was concerning the administration of ergot; not that its use in any degree caused the inversion; there is not one fact which could suggest such a presumption, but that the condition of tonic spasm of the uterus, which prevented the immediate reduction of the displaced organ, might have been excited by the drug. I am assured, however, by the remarks which have been made, that such a spasm might have been induced by the presence of the fundus in the cavity of the uterus. In this they are confirmed by no less an authority than W. Tyler Smith, a reference to whom has been made in my report.

The remark made by Prof. Miller, viz: that the fundus may be indented by the tips of the fingers, when compression of the uterus is injudiciously made, I hold to be of paramount importance. In this connection I may be permitted to allude to the dangers attending Credé's method of expressing the placenta. In using this method, we are instructed to seize the uterus in both hands, and to squeeze out the after-birth. Practically one does not compress the uterus uniformly in all its axes; the abdominal parietes render the posterior surface of the organ inaccessible, and the tips of the fingers are forced to press upon the fundus. Now, under certain conditions, is it not reasonable to suppose that the paralyzed fundus may be indented in this manner? In fact, I have no question but that, in the case under discussion, the point of departure was in the compression which was used under my direction.

The plan of compressing the abdominal aorta from within the uterine cavity, alluded to by Dr. Nelson, has long found a place in the literature of the subject, and is spoken of by Cazeaux. When the uterus is large, the procedure has the advantage claimed for it, namely, that of quickly recognizing any descent of the fundus. But it is an agonizing operation. Moreover, in order to compress the artery, the hand must be carried above the fourth lumbar vertibra, or nearly to the umbilicus, and this interferes with the

proper retraction of the uterus. On this account, I give preference to compression through the abdominal parietes.

Concerning the cause of puerperal inversion, all observers have remarked that unusual distension of the uterus, as exists in some cases of multiple pregnancy, and in dropsy of the amnion, is a condition which favors the accident. But upon the initial step in the process of inversion, the profession seems divided. One class of observers hold that it is a condition of irregular contraction of the uterus, whereby it is inverted; in other words, that the process is an active one in its very beginning. Prof. Byford has very clearly given us the *modus operandi* of this process, for which he has expressed his preference. It is especially dwelt upon by W. Tyler Smith, its author, who has likened the process to inversion and intussusception of the intestine, upon the one hand, and speaks of its relations to spasmodic rigidity of the os uteri, and so-called hour-glass contraction with retention of the placenta. It may be said, in support of the active process, that the virgin uterus has been known to invert itself by unceasing contraction of the organ.

Another class of observers believe the first step in the process to be passive, so far as the uterus is concerned. and that the fundus falls into the body by its own weight, or is pushed, or drawn downward through some external force.

I am impelled to accept the latter as correct. It is true that I can only speak upon the authority of a single case, but it will be conceded that the opportunity for observation was as good as it was rare. At a given moment, I felt the outlines of the symmetrical but flaccid uterus, its fundus reaching nearly to the umbilicus. Shortly afterward, the organ had contracted, and its fundus was gone. Now, what occurred in that short interval? Of course positive knowledge is precluded, because the fundus of the uterus cannot be inspected, and my hand was not in the cavity of the organ. Bnt of one thing I feel convinced, namely, that there was no contraction, partial or complete, of the uterus before the fundus had fallen. In reality, the recognition of the contraction and the discovery of the absence of the fundus were simultaneous. From this moment, however, till the last, the uterus was in a state of tonic spasm. Had the victim survived the

shock, I can easily understand how this contraction may have propelled the fundus, and have made the inversion complete.

There is one other condition which I think can have an influence in determining this accident. Dr. Merriman has called our attention to a predisposing cause laid down by Barnes, namely, the location of the placenta at the fundus. I desire to ask the Fellows if it ever occurred to them that the location of the placenta at the fundus is extremely infrequent, quite as accidental, and, it may be, as rare as its location in the cervical zone? Perhaps in this fact Dr. Jackson, and others, may find one explanation of the great rarity of puerperal inversion of the uterus. I have many times determined the location of the placenta, through the uterine souffle, but have never yet found the area of the greatest intensity of the souffle to be at the highest part of the uterus. I regret that the location was not ascertained in the case before us.

The usual site of the placenta, in the right or left lateral half of the uterus, upon its anterior or posterior wall, I hold is not a matter of chance, but is determined by a condition of the uterus which obtains in the very earliest days of pregnancy.—You will recall that when the impregnated ovule reaches the cavity of the uterus, it finds the lining of the organ, the decidua, so swollen that the walls of the uterus are in apposition, and no cavity can be said to exist. Observation has shown, however, that the nearest approach to an unoccupied space within the uterus, is at the superior angles of the organ. When the ovum escapes the uterine opening of the Fallopian tube, it is not impelled to insinuate itself between the apposed deciduæ, but attaches itself naturally at the upper angle of the body, where, as we have just seen, there is the most room. It is the attachment of the ovum which determines the location of the placenta.

After the third month of pregnancy, the fundus of the uterus contributes most in forming the increasing cavity of the body. So disproportionate is this growth that, at the end of pregnancy, the Fallopian tubes seem to be attached to the uterus in its lower third, instead of near the superior point, as in the unimpregnated state. The placental site remains the same, and though it may increase in size by its own growth, it can never be carried upward by the gradual ascent of the fundus. I am aware that

when the empty uterus contracts upon itself after delivery, the highest border of the uterus very nearly approaches the placental site; still then the greatest portion of the latter will be inferior to a line drawn between the uterine opening of the Fallopian tubes.

If my reasoning is well founded, the conservative design of nature must be acknowledged; for we are told by Barnes that a momentary paralysis of the placental site usually exists after labor, and Prof. Miller has said that the uterine tissue is thicker and heavier at that point. I cannot but think that this paralyzed, heavy area would very frequently descend from its normal plane, if the site were at the highest part of the uterus. But, grace to the fact that the site is mostly upon the side of the spheroid, its tendency is to fall outward.

I am not aware that these views have been expressed by others, but I have held and communicated them to my class for three years, and have confirmed the observation concerning the usual site of the placenta by many auscultatory examinations.

I desire again to thank the society for the interest which has been shown in the subject and specimen introduced by me.

ARTICLE X.

INDIANA, ILLINOIS AND KENTUCKY TRI-STATE MEDICAL SOCIETY.

The fourth annual meeting was held in the Hall of Representatives, in the city of Springfield, Ill., Nov. 13, 14 and 15, 1878.

The society was called to order at 11 a. m., by the president, Dr. James F. Hibbard, of Richmond, Ind. The session was opened with prayer by Rev. G. H. Fullerton.

Judge J. H. Matheny, on behalf of the citizens of the State and city, made a brief speech of welcome to the Society, paying a high tribute to the pioneers of our profession.

Dr. Theophilus Parvin, of Indianapolis, responded to the judge, in a brief and eloquent speech.

Dr. B. M. Griffith, chairman of the Committee of Arrangements, submitted his report, which was adopted. The report

gave the order of exercises and the programme for each day; it also stated: "This society has no ethical matters to discuss, not proper in any medical organization, its sole object being the reading and discussion of scientific papers and cultivating professional sociability." And yet, none are received to membership who are not members of some local society auxiliary to the American Medical Association.

After calling the various committees, the society adjourned to 2:30 p. m.

AFTERNOON.

Dr. Hibbard, the president, delivered the annual address, which treated at some length of the functions of the nerves and of the brain.

Dr. David Prince, of Jacksonville, read a paper on the "Metric System." The reader gave illustrations upon the blackboard, and explained the practical advantages of the system.

Dr. J. M. Holloway, of Louisville, read a paper on "Muscular Rigidity—a Symptom, Cause or Result of Disease." The doctor reported several cases in illustration.

Adjourned to 7:30 p. m.

EVENING.

Dr. J. Adams Allen, of Chicago, delivered a public address on the "Nervous System."

Dr. J. W. Singleton, of Paducah, Ky., read a paper on the "Medical Heroism" of 1878. The doctor recounted the sacrifices made by the members of the profession in the great scourge of the year. It is to be hoped that the entire profession will pay the tribute due to the memory of "our fallen heroes." Who can say that the bravery of Cook, Reuter, Rodgers, Saup, Easley, Woolfok and hosts of others, who Christ-like gave their lives for men, has ever been excelled?

Adjourned to 9 a. m.

NOV. 14.—SECOND DAY.

Dr. T. Parvin, Indianapolis, read an interesting paper on "Perineoplasty." The doctor reported several cases of perineal rupture treated by this method.

"Modes of Administering Mercury in Syphilis," was the subject of a paper by Dr. J. W. Thompson, of Paducah, Ky.

Dr. J. S. Hodgen, of St. Louis, read an exhaustive paper on "Section of the Superior Maxillary Nerve." The various surgical operations resorted to in the treatment were presented and clearly illustrated by suitable drawings.

AFTERNOON.

Dr. Thos. F. Rumbold, St. Louis, read a paper on the "Treatment of Scarlatina," dwelling at some length on mechanical therapeutics.

Dr. J. S. Jewell, of Chicago, reported on recent researches in the anatomy of the spinal cord.

Officers for the ensuing year were elected as follows: President, Dr. J. A. Ireland, Louisville, Ky; 1st Vice-President, Dr. J. W. Compton, Indiana; 2d Vice-President, Dr. B. M. Griffith, Illinois; 3d Vice-President, Dr. J. M. Holloway, Ky. Secretary, Dr. G. W. Burtal, Mitchell, Ind.; Assistant Secretary, Dr. H. H. Dening, Pana, Ills.; Treasurer, Dr. F. W. Beard, Vincennes, Ind.

Chairmen of Sections.—Surgery, Dr. J. M. Keller, Hot Springs, Ark.; Practical Medicine, Dr. S. H. Charlton, Seymour, Ind.; Obstetrics, Dr. H. B. Buck, Springfield, Ills.; Gynæcology, Dr. J. W. Singleton, Paducah, Ky.; State Medicine, Dr. Thad. M. Stevens, Indianapolis, Ind.; Pathology and Microscopy, Dr. S. L. Mathews, Springfield, Ills.

Chairman of Committee of Arrangements for 1879.—Dr. A. M. Owen, Evansville, Ind.

Time of next meeting, first Tuesday in November, 1879; place, Evansville, Ind.

A paper on "Pelvic Cellulitis," was read by Dr. J. A. Ireland, Louisville.

"Finger Stumps" formed the topic of the next paper, by Dr. H. C. Fairbrother, East St. Louis.

Adjourned to 7:30 p. m.

EVENING.

Dr. E. H. Gregory, of St. Louis, read a paper, entitled, "What is man?"

Adjourned.

By special invitation, the Society attended a reception at the Executive Mansion. His Excellency the Governor, Mrs. Cullom and their daughters, gave the society a welcome that will be a pleasant recollection to every member in attendance.

NOV. 15.—THIRD DAY.

Dr. Thad. M. Stevens' paper, "Some Thoughts on Certain Medico-Legal Questions," was read by title.

Dr. Sarah H. Stevenson, of Chicago, read a paper entitled, "Education of the Senses."

Dr. J. M. Keller, of Hot Springs, Ark., read an interesting paper on "Yellow Fever." The Doctor believes that "national quarantine" is the remedy for this terrible scourge.

Dr. J. W. Compton, of Evansville, followed, in the afternoon session, with a paper on the same subject. He believed the poison was solid, but not of any form of life; that it attached itself to walls and exposed surfaces. He believed the only preventive was a strict quarantine, and a stringent local enforcement of sanitary measures.

A Committee on Quarantine was appointed by the chair, to report at the next annual meeting, consisting of Dr. J. M. Keller, Hot Springs; Dr. D. H. Chase, Louisville, Ills.; and Dr. E. S. McIntire, Mitchell, Ind.

The papers, after discussion, were all referred to the Committee on Publication.

A number of papers were read by title and referred.

Society adjourned to 8 p. m.

According to previous notice, the work of the Society was to conclude with a microscopic exhibition, under the management of S. L. Mathews, chairman of section on Pathology and Microscopy. There were present thirty-five instruments, and objects of every description. Jacksonville Microscopical Society, fourteen in number; the first was a monocular, in charge of Dr. H. K. Jones; object, the circulation of the blood in a frog's

foot. Dr. G. V. Black, with his binocular, exhibited the circulation of the blood in the lung of the frog. Miss Fuller exhibited ocean shells; Dr. Pitner, viscera of rabbit; Mrs. Mulligan, pollen of lily; A. E. Prince, fly and spider's eye; Miss Rhodes, living hydra. Several other instruments, in charge of Drs. Frost, Winslow, Corwin and others. Dr. Mathews manipulated nine instruments, namely: the Henry Crouch, great binocular, the intermediate, the student's monocular, the educational monocular, the queen binocular and monocular, and two of Bullock's monoculars, of Chicago. Dr. M. exhibited trichinæ from pork; itch mite, human blood, deep sea soundings, etc. Close by was Dr. V. S. Lindsay, with his Hartnack monocular, and about fifty pathologico-anatomical specimens. Near him was the writer, with Ross monocular, specimens all pathological. Next came the tables of the Chicago society, two instruments in charge of Dr. Danforth, who also exhibited the circulation in the frog's foot, lung and the action of the heart. J. G. Langguth had ten instruments, with every variety of mounted objects; the most interesting was a living trichina.

With a vote of thanks to Governor Cullom, the citizens of the State and city, the society adjourned, to meet in the city of Evansville, Ind., first Tuesday in November, 1879. B.

A CHEERFUL PROSPECT FOR PHYSICIANS IN CHICAGO.—The Chicago organ of one of our religious "denominations," urges its readers to promote the social element in the church by following the example of a family where there was an informal social gathering. "No refreshments were served, but at one corner was a table with cold water, popped corn, raisins, walnuts and doughnuts."

There is a demand for ostrich pepsin in the retail drug trade; and it is understood that the homœopathists are preparing a tenth decimal trituration of "cold water, popped corn, raisins, walnuts and doughnuts."

Foreign Correspondence.

ARTICLE XI.

CLINICAL NOTES FROM THE SERVICE OF PROF. PÉAN, HÔPITAL SAINT LOUIS, PARIS.

Though Prof. Péan is not a very dashing or brilliant operator as far as the mechanical execution of his surgery is concerned, yet as a teacher he is undoubtedly one of the first, if not the very best in Paris.

The Saint Louis, which contains 853 beds, is situated in the midst of a great manufacturing district of the French capital, and is devoted mostly to surgical cases.

This great amount of material is systematically arranged and presented for the purpose of teaching. Cases are grouped together in such a manner that we are generally able to see several patients affected with the same disease during a single day, as well as the operations done on them.

Tumors and other morbid growths are studied first in their general aspect, and then microscopical specimens of the same are prepared which all have a chance to carefully examine.

On Saturday, Nov. 2d, the first cases brought into the amphitheatre were two women suffering from uterine fibroid.

The Professor said: "I bring before you to-day two cases of disease among the most interesting known to the domain of either medicine or surgery; interesting because we are sometimes able to do wonders in the way of curing our patient, and at others are absolutely helpless to render her the least assistance.

"The first thing to be done when a case of uterine fibroid presents itself to you for treatment, is to ascertain by a careful

examination the exact location of this growth in its relation to the uterus itself. In other words, Is the tumor extra-uterine, intra-mural or intra-uterine? The first of these cases that will occupy our attention is a woman 36 years of age, who has borne one child, now fifteen years old. The tumor, in her case, though occupying the interior of the womb, is attached and bound down to the walls of the uterus in its whole extent by the mucous lining of that organ, and is therefore termed a sub-mucous fibroid. It is as large as a child's head one year old, and occupies one side and the posterior aspect of the uterine cavity.

"When the patient presented herself to me three weeks ago, she had been flooding for many months, and was consequently very anæmic.

"Although in the management of these cases there is no single line of treatment that has not its advocates and its opponents, yet all, I believe, are agreed that a thorough dilatation of the mouth of the womb exercises generally a beneficial influence at least upon the hæmorrhage that is so often one of its most dangerous and perplexing symptoms. A great many devices have been used to effect this object.

"The one that I prefer, and the one which I practiced on this patient three weeks ago, was to incise the mouth of the womb freely with Dr. Paquelin's thermo-cautery. I first make my incisions laterally, and if they do not open the parts sufficiently freely I also incise the anterior and posterior lips.

"The advantages of this procedure over the knife or the scissors are that you have no hæmorrhage, and also that your cut surfaces do not so readily heal as they do when made by a cutting instrument.

"After I operated in this manner on this woman, she nearly ceased flooding, and has lost but little blood since.

"I shall now proceed to perform the next step in the operation in this case, as the womb is now well open, and I can get free access to the tumor. This second step in the management of our case consists in puncturing this mass at several points with the conical point of the thermo-cautery."

He then produced anæsthesia with chloroform, introduced a large wooden cylindrical speculum, after which he punctured the

fibroid mass at three points with his thermo-cautery, introducing it to a distance of about six centimeters. He then proceeded to incise the mouth of the womb in the second case as he had done in the first, and proposes to treat her, after a few weeks, in the same manner as he did the first case described.

I saw the first of these patients twice after she was operated on. She had a good deal of discharge from the uterus, though an insignificant amount of constitutional disturbance. At the end of two weeks she was sent out of the hospital, to remain for a month, at the end of which time she will return and have the operation of puncturing this tumor repeated.

Prof. P. claims that in several cases this mode of treatment has been very successful in his hands, the reaction produced by the introduction of the cautery leading to the absorption of the morbid growth.

Carl Braun, of Vienna, would manage a case like this by first dilating the mouth of the womb well with a sponge tent and then making a free incision through the mucous covering of the tumor from top to bottom, then giving ergot freely to bring on uterine contractions.

Prof. Shröder, of Berlin, is opposed to meddling with these cases in any way if they are very anæmic until improvement in the general condition of health has been obtained. He has, he says, so often seen the most disastrous results follow the least disturbance of these cases where the patient is very bloodless, that he dreads them more than almost any class of cases that come under his observation.

In a case that I saw him manage he dilated the womb and then used cold injections of a solution of carbolic acid and proposed to wait before doing anything more active until his patient was in a better physical condition. There is no principle in surgery now more generally recognized than that which associates as cause and effect the septic processes that follow operations and an extremely anæmic condition of the subject operated on.

Saturday, Nov. 9th, 1878. Prof. Péan brought into the amphitheatre to-day a number of cases of bursal tumors situated at or near the wrist joint. He said: "A great variety of plans had been adopted in the treatment of these cases; but the first step to

be taken was to determine with *accurracy* whether the bursa communicates by a fistulous opening with the joint *itself*, or whether it simply involves the tendon of the muscle.

"If you find that by firm pressure you are able to press the contents of the bursa out into the joint, then great care must be observed in its management. This last condition of things, however, is the great exception.

"The failure to make this simple distinction in these tumors has led to an endless amount of useless discussion as to the best manner of treating them."

He opens them by a large valvular incision, keeping the knife in the wound until all the fluid is pressed out. He then uses pressure on the seat of the tumor by means of a rubber band encircling the wrist, a short wide piece of wooden splint being put under the band, to keep it from exercising too much pressure upon the circulation of the hand.

Prof. Lister opens these bursæ under the spray and dresses them antiseptically without the least fear of any evil results.

In obstinate cases of "housemaid's knee," I saw Prof. L. open the bursa in the same manner, keeping the patient in bed for a few days, and they recovered without any inflammatory or constitutional disturbance following the operation.

Saturday, Nov. 16th, 1878. The first case shown us to-day was that of a girl 18 years of age and apparently in good health. Prof. Péan said: "The first case I show you to-day is one of great interest in a diagnostic point of view. The tumor that I show you occupying the axillary region in this young girl, is about the size of a goose-egg and was first observed about nine months ago.

"It grew very slowly until the last three months, when it began to increase in size rapidly, and has lately, by its pressure upon the axillary plexus of nerves, caused the patient a great amount of suffering. The first question that we ask ourselves is, What is this growth? What are we most likely to have in this region?

"Adenitis involving the lymphatics, will be the very natural answer. This adenitis may be acute or chronic, it may be suppurative in character, or it may be accompanied by a simple hyper-

trophy of the gland-structure with no tendency to a breaking down of its substance.

"But the case we have before us differs essentially in its physical aspect from either of these usual forms of glandular disease found in this region. First, we have no fluctuation, and have not therefore to deal with a cyst. Second, when I take hold of this tumor and attempt to move it, I find it firmly attached to the pectoral muscle that underlies it. I find, in fact that the growth has invaded the tissues in every direction. The skin is not yet involved, on account, perhaps, of the great thickness of adipose tissue that lies beneath it. I have not therefore the slightest hesitation in pronouncing this growth one of a malignant type."

He then cut down upon the tumor by a long incision, extending from the middle of the axilliary space down the outer aspect of the mammary gland a distance of about 18 Cm. He then began below, and dissected up the mass from the pectoral muscle, and when he had nearly reached the upper border of the tumor, he remarked that as he found it attached pretty firmly to the sheathes of the large plexus of vessels in this region, he must proceed with great caution. Cutting at the same time nearer the growth with his knife, he cut into it, and a large quantity of healthy pus flowed out and the whole thing collapsed. It was simply an indolent form of suppuration of one of the lymphatic glands. Its sac had taken on an inflammatory change and had involved the surrounding tissues in the same process.

Prof. P. at once recognized and acknowledged his error in diagnosis, but proceeded to carefully dissect out the sac, and consoled himself by remarking that his operative procedure was probably the best manner of treating this cyst, for if he had simply opened it and injected its cavity with tincture of iodine he might have had great difficulty in curing it, whereas by this single operation recovery was sure to follow.

Among other cases of interest operated on at this date was a young man, aged 19 years, who, eighteen months before, was taken with an indolent form of orchitis, which gradually went on to suppuration, and in spite of all treatment the process had continued up to this time. Lately the patient's health had begun to fail, and Prof. Péan believed that the testicle was affected by

a tuberculous form of disease, and that the patient was in imminent danger of having his whole system contaminated by this tubercular poison.

He proposed castration as the only remedy. He dwelt at length on the necessity of treating this class of cases promptly and intelligently, and said that, in the early part of his professional life he had allowed many cases of this kind to run into a general tuberculosis of the lungs by delaying the operation that he now proposed to perform on this patient.

OCCLUSION OF THE VAGINA.

Saturday, Nov. 23, 1878.—Our first case to-day was that of a woman 32 years of age, suffering from occlusion of the vagina. Three years ago she had had her first child. Following this she had some form of uterine disease, for which she was treated by a physician in one of the provincial towns. About eight months ago she had a very strong application made to the mouth of the womb, followed by a good deal of pain and vaginal discharge.

Since that time she had not menstruated, and had lately sufferred a good deal from pain in the lower part of her abdomen. Examination by palpation showed her womb considerably enlarged, extending eight or ten centimeters above the symphysis pubis. The finger could only be introduced into the vagina for a distance of two and one-half centimeters, at which point it came in contact with a firm resistance which could not be overcome.

He said that occlusion of the vagina was not a very infrequent accident following the use of very strong caustic applications to the mouth of the womb. He had no doubt but that the acid nitrate of mercury had been used in this case, but even the free cauterization of the mouth of the womb by the nitrate of silver might be followed by this untoward result if care were not taken to free the upper part of the vagina from all excess of the substance used. If this occlusion were only a kind of band or bridle, thin in texture, we might break it up with the finger.

After attempting this mode of procedure and failing in it, he introduced a large sound into the bladder and the forefinger of the left hand into the rectum, as guides to the direction in which he was to make his incision, and using a long bistoury he gradually

cut his way through the occluded part of the vaginal walls. A considerable amount of a black, tarry-looking fluid flowed out when he had passed through the occlusion. The menstrual fluid which had been dammed up by the obstacle that prevented its escape had burrowed down somewhat in the direction of the vaginal outlet, and so had considerably facilitated the operation of reaching the mouth of the womb.

He proposes to keep the parts open by the introduction twice a day of a quadrivalvular speculum, gradually extending the blades of the same until the vaginal cavity is of the requisite size. He considers this manner of dilating and keeping the parts open as better than the use of any of the special dilators made for that purpose.

I treated myself, a few years ago, a poor woman who very nearly suffered from this same accident, by the attempted application of a chloride of zinc paste to the mouth of the womb, for the removal of what was *supposed* to be a cancerous tumor.

The person who used this "cancer plaster" did not get his application to the mouth of the womb but applied it to one side of the cervix, the effect of which was to destroy a considerable portion of the left wall of the vagina at its junction with the neck of the womb itself. When the wound healed the contraction of the cicatrix that remained drew the upper walls of the vagina together, narrowing this portion of its cavity to about one-third of its natural capacity.

The cervix uteri was also drawn considerably towards the left side, the body of the same falling towards the right, thus producing a latero-version of that organ. The result of this alteration in the texture and relation of the parts was to render coitus very painful, produce a bearing down sensation when the patient was on her feet, and in fact to render her a perfect invalid. For the relief of these symptoms I attempted to divide these cicatricial bands first by a number of superficial incisions with the knife. Fear of hæmorrhage deterred me from making my incisions very deep so I made but little progress in the treatment of my case until it occurred to me to try the elastic ligature. I threaded a large curved needle with one of these ligatures, passed it deeply into the parts and tied it firmly. At the end of

twenty-four hours it had cut its way through the hard mass and I had the satisfaction of having an incision deeper than I would have dared to have made with the knife. By repeating this process at other points in this band I was able to partially overcome the deformity and considerably benefit my patient.

In the last students' number of *Le Progrès Médical* there are several pages devoted to the system of medical education in vogue in the different countries of Europe as well as a review of the medical school system in the United States.

The writer says that *unfortunately* the State does not control medical education in America. That our students begin often with no primary education, have generally greatly inferior advantages for the pursuit of their studies, and secure degrees after studying one-half of the time that is required in France to get a permission to practice as a veterinary surgeon.

Unfortunately and unjustly our whole profession are suffering in the eyes of foreign physicians for the short-comings of our medical educational system.

In Germany I found intelligent professors who had an impression that all the medical schools of Philadelphia sell their diplomas after the fashion of the eclectic concern that has been not only a disgrace to our profession but to the good name of every American.

W. S. CALDWELL.

PARIS, Nov. 30th, 1878.

LIEBIG'S EXTRACT OF MEAT.—When Baron Liebig stated that his discovery of Extract of Meat would prove one of the most beneficial to mankind of his various discoveries, he had no conception of the enormous extent of consumption which the future would develop. From a few hundred Bavarian oxen, which were originally sufficient to supply the continued demand, the total of cattle since used by the Liebig Company, exceed 1,500,000 head.

Domestic Correspondence.

ARTICLE XII.

CHICAGO, Dec. 12th, 1878.

Editor Chicago Medical Journal and Examiner:

So many of your readers have had a loving friendship for Dr. Lucius Clark, whose obituary appeared in your last number, that perhaps a few additional words of appreciation will find an acceptable place in your columns.

The writer has known him well for many years, and desires to express his thorough respect for Dr. Clark's character, both as a physician and a man. He was full of an enthusiastic love for his profession, which induced him to seize every moment he could spare from a laborious practice to study upon the subjects pertaining to his cases. His shelves were full of the best medical works, and the best journals of our country were always upon his table. He said to the writer, some twenty years ago, "Unless I am unusually fatigued, I make a point, before I retire, of looking over whatever journals come during the day, for I always get some good out of them." Not only did he read much, but he pondered upon it until it became thoroughly his own. Prof. Armor, of Long Island Medical College, wrote of him: "I have always regarded Dr. Clark as one of the most sagacious and able practitioners that I ever met at the bedside." Prof. Armor but expressed the general feeling in regard to him as was shown by the frequency with which he was sought in consultation by the physicians of Rockford and the neighboring towns.

He possessed a remarkable influence over young men. The writer remembers the keen interest and delight with which, when

a boy at college, he and his classmates listened to the conversation of Dr. Clark, which not only interested and instructed, but always stimulated to higher attainment. Few possessed this power in a higher degree or used it better than he. He loved jokes, but sarcasm, ridicule and coarseness were beneath him. Wherever he went, he carried an atmosphere of good cheer and refinement.

So thorough was his love for his profession, that it affected young men like a contagion, making them think no work so noble or so grand as the physician's, and in consequence he was continually sought by those wishing to study medicine. It was his invariable custom to urge upon these the need of a liberal education first, saying, "the people continually require better educated men for their physicians, and if you would succeed, you should take a collegiate course or its equivalent before commencing professional studies."

Students from his office have nearly every year matriculated in the medical schools of Chicago or New York. His two sons have chosen their father's profession, and are working earnestly in it.

Dr. Clark was a religious man, taking great pains to be regular in his attendance at church, and his pastor always felt that in him he had a true helper, but his piety was of a kind that showed itself in deeds rather than words.

His memory will be warmly cherished in many hearts.

H. P. MERRIMAN.

IN order to facilitate the introduction of the metric system, as well as to furnish a convenient posological table, The Chicago Metric Club have published a Visiting List Dose Book, in which the doses are given both in the metric and in the apothecaries' weights and measures. It is light, and neatly bound in flexible silk covers, so that it may be carried in the visiting list or pocket without inconvenience. All physicians interested are urged to aid in placing this little book in the hands of the profession, not only by sending for it themselves but by ordering it for their friends. Sent free on receipt of six cents in postage. Address, THE METRIC CLUB, 181 Clark Street, Chicago.

Editorial.

ARTICLE XIII.

THE MARINE HOSPITAL SERVICE.

Those of our readers who have observed the changes that have been lately wrought in the U. S. Marine Hospital service, must have been greatly encouraged by the reflections they suggest. Time was when its affairs were in a state of utter confusion and chaos. They were administered in the interest of politicians, by officers who were themselves the creatures of scheming congressmen, and in most instances, instead of being selected on account of their fitness to perform the duties to which they were appointed, the reason for their appointment was that they or their friends had been, or might become, useful in some political campaign.

As a consequence of the want of system and organization and the incompetence of official incumbents, the service was a great expense to the United States Treasury. Hundreds of thousands of dollars were annually expended without the poor sailors receiving a moiety of the benefit that is now realized from the same expenditure. Great praise is due to ex-Senator Logan, in this connection, for the effective work he performed in congress. It was through his influence mainly that the office of Surgeon-General of the Marine Hospital Service was created, and the present efficient occupant of that office selected. No one can doubt the wisdom of the course pursued by Senator Logan, either in reference to the office he aided in creating or in the selection of Dr. John M. Woodworth to worthily fill it.

The marine hospital service, under Dr. Woodworth, has been literally reorganized. Its affairs are now administered honestly, wisely and economically. It is no longer an expense to the gov-

ernment, as it once was, but its income now covers the cost incurred by the excellent and efficient attention given to sick and disabled sailors.

It is only necessary to look at some of the measures the chief has inaugurated to see how all these good results have been accomplished. He has wrested the management of the service from politicians, and taken from them, all the power they formerly possessed in making appointments to its offices; and this was no easy task as we happen to know from a somewhat intimate acquaintance with the matter. Dr. Woodworth passed through many an ordeal in his efforts in this direction, and more than once his friends had reason to fear that he would loose his official head. This, however, was a necessary step preliminary to success in obtaining a sound organization. The next thing to do was to secure intelligent and trustworthy subordinates. In place of a hap-hazard method, each applicant for a place in the service is now subjected to a rigid examination by a board of surgeons convened annually at Washington city. The examination extends over five days and consists in a thorough test of the professional qualification of all who aspire to become officers. This extends to their preliminary education and moral character, and also to clinical examinations at the bedside of the patient. Those passing the highest grade are appointed assistant surgeons.

All vacancies in the rank of surgeons are filled by promotion from the grade of assistant surgeons, on the grounds of merit and fitness alone.

These are some of the most important measures adopted by the Surgeon General to perfect the Marine Hospital Service; others of minor consideration we do not consider it necessary to mention. In addition to the faithful and efficient discharge of these onerous duties connected with his office, and which are to a great extent self-imposed, Dr. Woodworth has found time to do a great deal for the profession at large. The corps of the Marine Hospital Service was the first to adopt the nomenclature promulgated by the Royal College of Physicians, London, which is now regarded by the profession generally as the best in use.

The officers of this branch of public service are now educating the profession of this country in the use of the metric system for

dispensing medicines, so well adapted in every way to this purpose.

To the Supervising Surgeon-General also is due the credit of urging upon Congress the quarantine act. He is now issuing and distributing bulletins of epidemic disease throughout the world, and while much of the space in them is occupied by subjects connected with the advance, prevalence and decline of yellow fever in this country, still telegraphic intelligence in reference to that disease and to cholera, etc., from the most distant parts of Europe and the East occupies a place in the reports. It requires no spirit of prophecy to foretell the great advantage which must result from this comprehensive system of gathering information of the rise, progress and approach of future epidemics. Our quarantine authorities will not only know of the approach of an epidemic disease, but will be informed, by name and description, of the departure from an infected district or port of every vessel that may be destined for this country.

If we mistake not, the idea, inception and execution of the plan of forming a yellow-fever commission to collect all the facts in reference to the prevalence of that awful scourge of the South, originated also with the Marine hospital management. The good that will flow from the creation of this commission, and their report to the Public Health Association, recently held in Richmond, is not all. These and other circumstances that are now of importance to the profession, strongly suggest the benefits that would arise from a national bureau of public health. In fact, the foundations are laid for it in such a way that sooner or later its establishment will be secured. We deem it but just to lay before our readers this rapid and imperfect sketch of the work accomplished by our fellow townsman, Dr. John M. Woodworth. He has made an indelible impression upon the sanitary record of this country; while the history of the United States Marine Hospital Service will point to his exertions in its behalf in all time to come. His is a deservedly prominent position, and one of which the nation should be proud.

ARTICLE XIV.

THE CHICAGO GYNÆCOLOGICAL SOCIETY.

On the evening of the 18th of October, 1878, a few gynæcologists of this city, by invitation, met at the house of Dr. W. H. Byford, to form a new medical society. Drs. DeLaskie Miller, A. Reeves Jackson, E. O. F. Roler, James H. Etheridge, T. Davis Fitch and H. W. Jones were present. Dr. Miller was called to the chair, and after an informal and somewhat lengthy discussion of the objects of the meeting, a resolution was passed to organize a society for the cultivation of knowledge in connection with obstetrics and diseases of women and children. In selecting a name suitable to represent the objects of the Society, the choice between an "Obstetrical" Society and a "Gynæcological" Society was freely canvassed. It was conceded that neither of these names was sufficiently comprehensive to embrace all the objects of the organization, but it was finally decided that the latter was capable of a wider application than the former; hence it was adopted, and the name, Chicago Gynæcological Society agreed upon.

The organization of the Society was completed by electing Dr. H. W. Jones secretary for one year. The secretary performs all the usual duties of that office, and, so far as necessary, exercises the functions of treasurer. There are no other permanent offices. The chairman is nominated and elected at each meeting. As yet there is no written constitution nor rules for the government of the Society, these being regarded as at present unnecessary. The meetings are held at the homes of the members by invitation, the last Friday of each month, at 8 p. m. precisely. The exercises of the evening consist of reading and discussing an appropriate paper once every three months, and at other meetings conversations upon such subject as may be agreed upon the evening previous. One member is selected at the time the topic for conversation is chosen, to lead upon the subject selected. After the discussion is closed, the members partake of a simple collation prepared by the host of the evening.

The first regular meeting was appointed to take place at the residence of Dr. H. W. Jones, on the evening of Friday the 25th of October. The following named gentlemen were invited to meet the Society at that time and place as original members, viz.: Drs. E. Warren Sawyer, Danl. T. Nelson, Henry P. Merriman, Chas. W. Earle, Henry T. Byford and E. C. Dudley.

At the second meeting it was resolved that candidates for membership should furnish the secretary a paper on some topic embraced in the declared object of the organization, and the recommendations of two members of the Society. At the meeting succeeding the nomination, the application must be accepted by a unanimous vote of all the members present.

We heartily wish success and prosperity to this new enterprise.

The fruits of the regular meetings of the Chicago Gynæcological Society are already seen in the reports published in the JOURNAL AND EXAMINER.

EASTERN CORRESPONDENCE.

We take pleasure in announcing that we have completed arrangements by which we expect to be enabled to present to our readers, at regular intervals throughout the current year, correspondence from able writers in Boston, New York, and Philadelphia, which will embody such practical information and news of current events, as will add to the value of these pages.

TELEPHONIC COMMUNICATION.

By the aid of the Edison-Gray telephone, and the ample facilities offered by the American District Telegraph Co., the members of the editorial corps of this journal will soon be within vocal distance of each other and their publishers, and will also be enabled to communicate, by the same instrumentality, with several of the hospitals and dispensaries of the city, and with an increasingly large number of professional men.

Reviews and Book Notices.

ARTICLE XV.—FIBROUS TUMORS OF THE UTERUS. A Clinical Lecture by W. H. Byford, M.D. (Seguin's Series.)

One interested in the progress of gynæcology must open eagerly pages which unfold the recent views of an expert respecting a field so fertile in doubts and discouragements heretofore, but now happily exhibiting some of its most brilliant successes.

Nor can there be any disappointment in store for the reader of the pamphlet bearing the above title, when he contrasts the usually limited scope of a clinical lecture with the fulness of diagnosis, adequacy of description, and the details of treatment here made manifest.

Dr. Byford, after examining his text cases, states that the relative frequency of these tumors, compared with those of ovarian origin has been, in his own experience, as ten to one; that they are homologous growths, but vary in regard to the ratio of their different constituent elements; in some ("myoma") the fibrous, in others ("fibroma") the connective tissues predominating, and that they originate in great and long-continued hyperæmia of the uterus.

Classifying fibroids, as usual, into submucous, intramural, and subserous, he clearly distinguished the characteristics imparted to them by reason of position and surroundings, and as well defines their retroactive influence upon the uterus itself. He accounts for their low degree of vitality and slow growth by the small size of their nutrient vessels, penetrating a condensed but not independent capsule, and shows how this fact contributes to a limitation of their development, and to their degeneration into lower forms of tissue, or to inflammatory disintegration. It is

interesting here to read that "a single tumor grows more rapidly, causes more vascularity in, and greater hypertrophy of the muscular fibres of the uterus than the multinuclear form. The latter often reaches a limit for want of vascular supply, or is transformed into dense tissue of a vitality far below that of a single tumor. It sometimes becomes a true fibroid degeneration of the whole uterus, in which one would hardly trace any of its own anatomical elements."

"Fibroids seldom take their origin in the cervical tissues."

Symptoms will vary with the variety of tumor, hæmorrhage and menorrhagia being most common to the submucous form. Leucorrhœa follows the same rule as do watery discharges, and this because here the vascularity of the womb is greatest.

"Dysmenorrhœa, if present, is of the obstructive kind, and is most aggravated where the tumor is multinuclear and submucous."

Not to quote too largely, it is pleasant to find the author announcing a generally favorable prognosis, "because these tumors occur mostly in persons who approach the menopausis, and often cease growth afterward; they grow slowly and for years without causing dangerous symptoms, and often cease enlarging from no discoverable cause; they sometimes degenerate into inert masses, not particularly inconvenient, and nature will often dispose of them by spontaneous expulsion; a judicious medical treatment is often efficient, or surgery interposes successfully for their removal."

In regard to the correlation of pregnancy and fibroid tumors, the author decides the former to be "most infrequent when the latter are submucous and confined to the central or upper zones of the uterus, and that the subserous forms are not so antagonistic."

In general, the larger the tumor the less likelihood of pregnancy, but if it occur, an impossibility of normal uterine development will lead to abortion. The danger of hæmorrhage under these circumstances Dr. Byford thinks to be over-rated.

The effect of pregnancy upon some of these tumors will be *nil*, but in very many cases, the subsequent process of involution set up in the uterus seems to extend to the morbid tissue and its decadence is thus assured.

Among remedies preventive of hæmorrhage, the author is particular to describe his method of preparing vaginal tampons, to be always on hand, and ready for introduction by the patient or her attendants. They consist of sponges, fine and large enough to fill the vagina, which have been saturated with a half strength dilution of the *liquor ferri persulphatis*, wound with a string to a proper shape and degree of compression, and laid away to dry. To introduce one of these when unwound, or to withdraw it by a cord passed through prior to suturation, will be no difficult matter. It may remain, if successful, forty-eight hours, when the hæmorrhage will be unlikely to return.

Considering the question of permanent cure, Dr. Byford alludes kindly to the "sorbefacient" remedies upheld by Atlee and others, but states that his own success with them has not fulfilled expectation. But he adheres positively to former views of the efficacy of ergot, which he affirms will cure one-third of the cases, and favorably influence two-thirds. In a recent address to the Obstetrical Society of Edinburgh, Dr. Alexander Simpson substantiates this opinion. Dr. Byford prefers to administer Squibb's fluid extract in doses of 1.33 C. C., gradually increasing till 12 or 16 Gms. are given daily. The larger doses are not used unless to promote expulsion of the tumor, and they frequently produce very distressing pain, which continues notwithstanding the withdrawal of the medicine.

Even opiates will at times fail to subdue the throes of the uterus till expulsion is complete, but the author affirms this violence of action to have done no real mischief in the cases under his own hands.

The question of the danger of using ergot in the subserous variety of tumors, Dr. Byford disposes of by calling attention to the fact that, in this case, the contractions induced are away from the axis of the tumor, and tend to pediculate it, or diminish its nutrient supply.

Gangrene of the extremities, or serious inconvenience to the nerve centers, have never fallen within the province of the author to see; nor does he seem to be alarmed by the degree of septicæmia caused during a slow disintegration and expulsion of the growth.

The use of electrolysis by Drs. Kimball and Cutter receives passing notice, but with a very qualified approval.

The mention of surgical treatment is confined to that appropriate to sub-mucous fibroids, and the author's first remark is that this treatment must be as simple as possible, compatible with thoroughness. Its dangers arise (1) from laceration or other damage to the uterus resulting in hæmorrhage or inflammation; (2) incomplete ablation, causing septicæmia; (3) shock, sometimes following protracted efforts at removal.

Dr. Byford enumerates ligation, torsion and amputation, and describes minutely the manner in which each is to be effected, giving a decided preference to torsion wherever applicable.

One misses here the credit that should be given Dr. Emmet for his plan of "removal by traction," relying upon the closely following uterine wall to pedunculate the mass as withdrawn and separated.

It is evident from his whole treatment of the subject, that Dr. Byford is no alarmist, and the student would do well to consider the experiences of other eminent authorities if he would rightly weigh the dangers arising from hæmorrhage, shock and septicæmia during the spontaneous, medicinal or surgical treatment of uterine fibroids. H. W. J.

ARTICLE XVI.—A CLINICAL HISTORY OF THE MEDICAL AND SURGICAL DISEASES OF WOMEN. By Robert Barnes, M.D., London, Censor of the Royal College of Physicians; Lumleian Lecturer (1873); late Examiner in Obstetrics and the Diseases of Women at the University of London and the Royal College of Physicians and Surgeons; Obstetric Physician and Lecturer on Obstetrics and the Diseases of Women to St. George's Hospital. With one hundred and eighty-one illustrations. Second American, from the second and revised London edition. 8vo., pp. 784. Philadelphia: Henry C. Lea.

The first edition of this excellent work having been for some time exhausted, the author has leisurely revised it, condensing many parts and adding one new chapter, on the "Relations of Bladder and Bowel Disorders to the Diseases of Women." He has also increased the number of the illustrations by cuts which

are not only new but, like a large proportion of the others, are original with Dr. Barnes.

This being the second edition of the work, an extended review is unnecessary, but there are a few points to which we would call attention.

We are pleased to note the pains the author takes in various parts of his work to caution his readers against becoming *mere* specialists. In the beginning of the second chapter he says: "There is nothing special in the mode of studying diseases of women." "The general or distant affections require to be investigated and treated; but it is not safe to overlook the organs that may be secondarily involved." "And there are disorders of this special system commencing in it, and in their turn acting upon and inducing disorders in distant organs or in the general system." In the fifth chapter he says: "Do not concentrate all attention upon this one region of the body. Remember that the fault may be in distant parts: that disease in other organs may complicate disease in the pelvic organs." "The great clinical rule should be: Interrogate all the functions; examine every organ. In this way only can we acquire a well founded confidence that important disease is not overlooked; in this way only can we rightly estimate the relations of symptoms to disease, and the reactions of disease upon distant organs, and frame a rational plan of treatment." In another place—"We thus see how dangerous it is to practice in the spirit of pure specialism; how absurd it is to map out the body and assign particular territories to particular classes of practitioners. It will be seen how intimately—how indissolubly—that part of medicine which takes for its basis the particular study of the generative system in women is linked with the disorders of the alimentary, vascular and nervous systems; that is, a pure specialty cannot exist. A more monstrous thing cannot be conceived."

Expressions like these indicate the broad judgment and liberal culture of the author, and make us feel inclined to accept his teachings as safe and judicious.

The work is well condensed, and we do not know a more reliable one upon the subject.

A few things about the book strike us unpleasantly. On page

375 the author says: "Radford, imbued with the teachings of this master (Dr. Blundell), encouraged Clay at the commencement of that career which may be said to have placed ovariotomy upon a secure foundation." "The operation was suggested by William Hunter; its practicability and the mode of performing it were taught by John Bell; it was first practiced, and that successfully, by an American, McDowell, a pupil of John Bell." How grudgingly he gives a little credit to Ephraim McDowell, yet implies that most of the honor belongs to his own countrymen!

The book appears in handsome dress—good paper, clear type, wide margins and excellent engravings. H. P. M.

ARTICLE XVII.—THE THROAT AND ITS DISEASES. Lennox Browne, F.R.C.S., Ed., Senior Surgeon to the Central London Throat and Ear Hospital; Surgeon and Aural Surgeon to the Royal Society of Musicians, etc. Henry C. Lea, Philadelphia, 1878. Jansen, McClurg & Co., Chicago.

This book is designed as a practical guide to the diagnosis and treatment of diseases of the fauces, larynx and nasal cavity.

The author's endeavor has been to give prominence to those facts which will aid the practitioner in making an accurate diagnosis, and selecting appropriate treatment; but he has omitted discussions of purely pathological interest, having, instead, simply referred the reader, for them, to other works.

In describing instruments and methods of treatment he mentions only those which he has found most efficient, in his experience of eleven years of practice, devoted mainly to diseases of the throat.

He has given especial attention to the illustrations—about one hundred and fifty in number—one hundred of which are colored, so as to represent, nearly as possible, the condition in the patients from whom they were taken. These add greatly to the value of the book for those who have only a limited opportunity to study diseases of the larynx.

The first eighty-six pages are devoted to the description of laryngoscopic and rhinoscopic instruments, and the modes of using them; together with a description of the anatomy of the

larynx and the semiology and general therapeutics of throat diseases.

Four chapters are devoted to diseases of the fauces, pharynx and nasal cavity, and the remainder of the book, six chapters, to diseases of the larynx.

The treatment suggested is not materially different from that recommended in other works of the kind, excepting in regard to morbid growths.

A single chapter treats of benign neoplasms in a light which will surprise many who have read of the brilliant results obtained by Lewin, Czermak, Morrell, Mackenzie, and others, by operative measures.

The author urges against instrumental procedures—that the functional disturbances produced by these growths is not usually grave; that many of the growths will disappear under local applications; that recurrence of the growths after removal is not infrequent; that the instruments now employed are more dangerous than formerly, and that injury of the healthy parts may lead to fatal results, while the irritation incident to efforts at removal may cause a benign growth to take on a malignant character.

Though we are not prepared to give up operative procedures within the larynx, we have no doubt that many of the author's objections are valid, and they should deter those from operating who have not special experience in the treatment of diseases of the larynx.

This is a valuable work, and we take special pleasure in recommending it to the profession for its excellent illustrations, but especially on account of the letter press, which has been admirably executed in large clear type.

We commend this book as a model for all who wish to publish medical works, which are far too often rendered almost valueless by being printed with small or indistinct type, which renders their perusal painful, and by a prolixity which exhausts the reader's patience.

E. F. I.

ARTICLE XVIII.—A MANUAL OF PRESCRIPTION WRITING. By Matthew D. Mann, A.M., M.D., Lecturer on Clinical Microscopy, and Examiner on Materia Medica, in the College of Physicians and Surgeons, New York; etc., etc. New York: G. P. Putnam's Sons, 1878. Chicago: Jansen, McClurg & Co. 12mo. pp. 155. Price 90c.

The appearance of another work on prescription writing, so soon after the book of Gerrish, is a sure indication that the necessity of greater care and better knowledge in the matter of prescribing is being duly appreciated by the profession. The book before us is more extended than Gerrish's, without being unnecessarily elaborate in details.

Besides the usual directions for writing simple and compound prescriptions, information about weights and measures, rules for the grammatical construction of Latin prescriptions, forms and examples of extemporaneous prescriptions, it contains a complete list of officinal preparations, and a very valuable table of the doses of all substances in the primary list of the U. S. Pharmacopœia. The doses are given in both the old and metric systems. The introduction of a chapter on the metric system is certainly demanded by the times. The method of writing this system adopted in this book, is that advocated by the JOURNAL AND EXAMINER, and found in every foreign medical literature except the English.

F. C. H.

ARTICLE XIX.—REST AND PAIN: A Course of Lectures on the Influence of Mechanical and Physiological Rest in the Treatment of Accidents and Surgical Diseases, and the Diagnostic Value of Pain. Delivered at the Royal College of Surgeons of England, in the years 1860, 1861 and 1862. By John Hilton, F.R.S., F.R.C.S., etc. Edited by W. H. A. Jacobson, F.R.C.S., Assistant Surgeon to Guy's Hospital. Second edition. New York: William Wood & Co. 8vo., pp. 299.

The well-known publishing firm of William Wood & Co., of New York, have entered upon a new scheme to supply the medical profession with standard works at marvelously low prices. They have opened subscriptions for "Wood's Library of

Standard Medical Authors," which shall contain only works of recognized worth. Each subscriber will receive one volume each month throughout the year. Subscriptions are taken: 1st, The $12.00, payable on delivery of the first volume, in which case the volumes are all delivered free, by mail, from New York. 2d, Payable $6.00 semi-annually, in January and July, in which case the subscriber pays express charges on the January and on the July volumes, the other volumes being sent free, by mail; and 3d, Payable monthly at $1.25 per volume; in this case the volumes are each delivered free, by express or carrier, C. O. D.

The scheme commends itself to all physicians who are desirous of obtaining a library of valuable medical books for a small outlay of money. And the selection of such books as Hilton's work on "Rest and Pain," which is to be the January volume of "Wood's Library," shows that the publishers are in earnest when they promise to furnish standard works to their patrons.

We hope many physicians will avail themselves of this rare opportunity to fill their shelves with useful books.

ARTICLE XX.—HARVEY AND HIS DISCOVERY. By J. M. DaCosta, M.D., Professor of the Practice of Medicine at the Jefferson Medical College. Philadelphia: J. B. Lippincott & Co. Chicago: Jansen, McClurg & Co. Octavo pp. 57; price 75c.

This little volume consists of an address delivered at the opening of the session at the Jefferson Medical College. It is a very fitting tribute to the memory of this famous man, in the tercentennial year of his birth, and is interesting reading for every physician and friend of history of medicine.

BOOKS AND PAMPHLETS RECEIVED.

A Manual of Physical Diagnosis. By Francis Delafield, M.D., and Ch. F. Stillman, M.D. Cloth, pp. 30. New York: Wm. Wood & Co. Chicago: Jansen, McClurg & Co.

Essentials of Chemistry, Inorganic and Organic, for the Use of Students in Medicine. By B. A. Whithouse, A. M., M.D. Cloth, pp. 257. New York: Wm. Wood & Co. Chicago: Jansen, McClurg & Co.

Clinical Diagnosis; a Handbook for Students and Practitioners of Medicine. Edited by James Finlayson, M.D., with 85 illustrations. Cloth, pp. 546. Philadelphia: H. C. Lea. Chicago: Jansen, McClurg & Co.

The Principles and Practice of Surgery. By J. Ashhurst jr., M.D. Second edition, enlarged and revised, with 542 illustrations. Leather, pp. 1040. Philadelphia: H. C. Lea. Chicago: Jansen, McClurg & Co.

Lectures on Bright's Disease of the Kidney; Delivered at the School of Medicine of Paris. By J. M. Charcot. Collected and published by Drs. Bourneville and Sevestre, Editors of *Le Progrès Médical*, and translated with the permission of the author, by Henry B. Millard, M.D. Cloth, pp. 100. New York: Wm. Wood & Co. Chicago: Jansen, McClurg & Co.

Lectures on Localization in Disease of the Brain. Delivered at the Faculté de Médicine de Paris; 1875. By J. M. Charcot. Edited by Dr. Bourneville. Translated by Ed. P. Fowler, M. D. Cloth, pp. 133. New York: Wm. Wood & Co. Chicago: Jansen, McClurg & Co.

Transactions of the Thirty-third Annual Meeting of the Ohio Medical Society, held at Columbus, May 14, 15, 16, 1878. Columbus, O.

Manual of Prescription Writing; With a Full Explanation of the Methods of Correctly Writing Prescriptions. A Table of Doses expressed in both the Apothecaries' and Metric Systems. Rules for Avoiding Incompatibilities and for Combining Medicines. By M. D. Mann, A.M., M.D. Cloth, pp. 155. New York: G. P. Putnam & Sons. Chicago: Jansen, McClurg & Co.

Practical Surgery, Including Dressing, Bandaging, Ligations and Amputations. By J. Ewing Mears, M.D., with 227 illustrations. Cloth, pp. 279. Philadelphia: Lindsay & Blackiston. Chicago: Jansen, McClurg & Co.

A Handbook of Nursing for Family and General Use. Published under the direction of the Connecticut Training School for Nurses, State Hospital, New Haven, Conn. Cloth, pp. 266. Philadelphia: J. B. Lippincott & Co. Chicago: Jansen, McClurg & Co.

The Pathological Anatomy of the Ear. By Herman Schwartze, M.D., with the Author's Revisions and Additions, and with the Original Illustrations. Translated by J. Orne Greene, A.M., M.D. Cloth, pp. 174. Boston: Haughton, Osgood & Co. Chicago: Jansen, McClurg & Co.

Harvey and His Discovery. By J. M. DaCosta, M. D. Cloth, pp. 57. Philadelphia: J. B. Lippincott & Co. Chicago: Jansen, McClurg & Co.

Transactions of the Pathological Society of Philadelphia. Vol VII. Edited by J. H. C. Simes, M.D. Cloth, pp. 175. Philadelphia: J. B. Lippincott & Co. Chicago: Jansen, McClurg & Co.

A History of the Diagnosis, Pathology and Treatment of Yellow Fever By J. B. Marion, M.D. Reprint from *American Practitioner*, Nov., 1878.

Holden's Human Osteology; Comprising a Description of the Bones, with Delineations of the Attachments of the Muscles, the General and Microscopical Structure of Bone, and its Development. By Luther Holden, F. R. C. S. Fifth edition, revised by the author with the assistance of Alban Doran, F. R. C. S. Cloth, pp. 286. Philadelphia: Lindsay & Blakiston. Chicago: Jansen, McClurg & Co.

The Principles and Practice of Surgery; Being a Treatise on Surgical Diseases and Injuries. By D. Hayes Agnew, M.D., LL.D. In two volumes. Vol. I. Cloth, pp. 1062. Philadelphia: J. B. Lippincott & Co. Chicago: Jansen, McClurg & Co.

Les Tumeurs Adenoides du Pharynx Nasal, leur Influence sur l'Audition, la Respiration et la Phonation. Leur Traitement. Par le Docteur B. Loewenberg. 1878.

De la Valeur Therapeutic des Courants Continues. Par le Docteur L. J. Teissier, Avec planches, intercallés dans la Texte. 1878.

Annual Report of the Secretary of the Treasury of the State of the Finances for the Year 1878.

The Duties of the Profession concerning Prostitution and its Allied Vices. By Fred. H. Gerrish, M.D. Reprint from the Transactions of the (Maine) Association, 1878.

Annual Report of the Surgeon General U. S. Army, 1878.

Diseases of the Nasal Cavity and the Vault of the Pharynx. Translated from the German of Dr. Carl Michel, with an introduction by E. L. Shurley, M.D., and C. C. Yemans, M.D. 1877.

Air and Moisture on Shipboard; A Fragment of Applied Physiology. By Th. J. Turner, A.M., M.D., Ph. D. 1878.

The Constituents of Climate, with Special Reference to the Climate of Florida. By F. D. Lente, A.M., M.D. Reprint from Richmond and Louisville *Medical Journal.*

Report of the Quebec Lunatic Asylum for 1877–8.

Automatic Cerebration as Related to Cerebral Localization. By J. K. Beauduy, M.D. 1878.

Transactions of the Colorado Medical Society, 1877–8.

The Structure of the Colored Blood Corpuscles of Amphiuma Tridactylum, the Frog and Man. By Dr. H. D. Schmidt. Read before the Royal Microscopical Society, April 3, 1878.

The Development of the Nervous Tissues of the Human Embryo. By H. D. Schmidt. Reprint from the *Journal of Nervous and Mental Diseases*, July, 1878.

Case of Repeated Attacks of Appoplexy with Aphasia. By Dr. H. D. Schmidt. Reprint from *Journal of Nervous and Mental Diseases*, July, 1878.

Summary.

Collaborators:

DR. H. GRADLE, DR. L. W. CASE, DR. R. PARK,
DR. R. TILLEY, DR. D. R. BROWER.

PRACTICAL MEDICINE.

TREATMENT OF GENERAL PROGRESSIVE PARALYSIS (DEMENTIA PARALYTICA). *Medical & Surgical Reporter.* Translated from the German of Prof. Ludwig Meyer by Dr. Liebmann, Nov. 2, 1878.

Prof. Meyer details a method of treatment that has been followed by remarkable success in this hitherto regarded incurable disease. He regards the disease as a chronic encephalitis, limited to the cortical layer of the convexity of the anterior half of the great hemispheres. He combats this condition by vigorous counter-irritation established as near as possible to the seat of the affection. He lays great stress upon his method of irritation, and as this treatment should be instituted in the very beginning, that is, before the necessity has arrived for the confinement in an insane hospital, we give it in full.

"The hair should be shaved off from the scalp in the region of the great fontanelle, to the extent of half a hand, and then as much tartar emetic ointment (1:4 Germ. pharm.) be rubbed in the central portion of the shaved surface as would cover a silver dollar. Much depends on the first application being accurate and energetic. A portion of the salve, as big as a pea, I caused to be rubbed on twice, by means of a firm and smooth pledget of linen of the size of a finger, and then I covered the reddened

surface with a piece of linen saturated with the ointment. The second application, which has to take place twenty-six hours later, ought to be made with the greatest care and precaution, in order to save the already loosened epidermis. Such denudation would cause considerable pain, and besides, would not benefit the procedure any, for this latter's success depends entirely on the feasibility of bringing the scalp, in its greatest possible depth, to swell and gradually to slough. Two applications, as a rule, suffice, but, to be cautious, it is well to spread, on the third day, a small portion of the ointment on the already elevated surface. During the third and fourth day the swelling increases, extends to the frontal region, and even to the face—rarely to the occiput and neck. As soon as the swelling increases, warm poultices should be applied freely. In a few days the integuments are detached by the abundant suppuration. The whole procedure requires on an average fourteen days, and leaves a regular, round, deep and copiously suppurating sore, which, by means of the basilic ointment, should be kept open for two or three months. During this whole time, and beyond it, if tolerated well, the patients are put upon iodide of potassium, in moderate doses (3–5, 0, aq. dest. 180,0, a tablespoonful four times a day). The diet, especially during the first weeks of this treatment, ought to be easily digestible, but vigorous. The patient should be sent into the open air as soon and as often as possible; should, if his strength allows it, do light work in the garden, but should be guarded against the heat of the summer's sun. Baths in any form are to be avoided, for they are, under these conditions, only too apt to produce congestion of the head."

Prof. M. has applied this treatment to seventeen cases of this disease. Of this number, two only remained under treatment fourteen days, one of these manifesting remarkable improvement; of the remaining fifteen, eight were cured; of these eight, one experienced a relapse from the too early abandonment of the treatment. A detailed history is given of the eight successful cases.

The article closes with a warning against a too energetic anti-syphilitic treatment.

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OBSTETRICS.

OBSTETRICAL ANÆSTHESIA. E. Hervieux. (*L'Union Médicale, Aug.* 27, 1878.)

The author is a partisan of obstetrical anæsthesia, and considers it as a veritable conquest of modern medicine. He protests against the opposition it has met with in France, but under conditions: 1st, that the indications and contraindications be clearly stated, and 2d, that the accoucheur always superintend personally the administration of the chloroform. Certain colleagues have presented obstetrical anæsthesia as practiced now-a-days, as completely inoffensive. This is an exaggeration and may cause the most dangerous consequences, of which the least would be to compromise the cause we would serve.

Undoubtedly there is no comparison to establish between surgical and obstetrical anæsthesia. The latter, as Campbell says, is only an analgesia. It does not abolish the intellectual and sensorial faculties; it does not take away the consciousness of self. It requires to obtain it (and this is capital) but very feeble doses of chloroform. It may be kept up for hours without difficulty, and without giving rise to coma or the stertor of surgical anæsthesia. The danger is then reduced to the smallest proportions, but not entirely removed. These are the proofs:

1st. There are subjects in whom the sensibility to the action of chloroform is excessive, and who only need a few inspirations of the anæsthetic agent to lose sense of feeling and consciousness. The author cites his own case in which the inhalation of chloroform for the extraction of a tooth, for about fifteen seconds plunged him into a profound sleep, and absolute insensibility. Cases of this kind are common with children, and not very rare in young women. Suppose an accoucheur has a case of this kind, and, encouraged by former successes, departs from the rules of prudence and gives large doses after the example of Simpson. Is it not evident that he may be surprised by comatose symptoms capable of endangering the life of the patient? The obstetrical effort may indeed, as Campbell says, bring the patient out of the coma, but this effort may be lacking as well as

the uterine contraction which follows it, and the danger then cannot be contested.

2d. In opposition to the exaggerated sensibility of certain women, there are organisms refractory to this action. I have met with some patients with an invincible resistence to the anæsthetic power of chloroform—invincible, at least, as regards the limits which I laid down for myself. It has seemed to me as if women, familiarized for a long time with the use of ether, or those who, under pretext of a need of tonics, have taken daily a considerable quantity of pure wine, are overcome by the anæsthetic agent with great difficulty. The author cites the case of a young woman to whom he gave about 100 grams of chloroform, obtaining but very incomplete anæsthesia. There is in this natural or acquired resistence to the action of chloroform, a danger which should be understood, for if one seeks only analgesia during the labor, he would only succeed by such an accumulation of doses that, at a given moment, he might no longer be master of the situation.

3d. I have encountered certain women who, after having solicited chloroform, had an excessive repugnance for absorption of its vapor. If one does not proceed like Simpson with large doses so as to plunge the patient rapidly into the anæsthetic state, it may happen that the patient will not take the chloroform, having been painfully impressed with the first inhalations, and not having had time to feel its benefits.

4th. Chloroform retards the labor. M. Campbell has recognized this fact, and observations made recently at the Maternité by M. Pinard confirm it. The intervals which separated each contraction were noted with care during one or several hours, then chloroform was given in moderate doses, and under its influence the internal instead of diminishing progressively, as occurs in a natural labor, gradually increased. There was one case, even, in which there was complete cessation of pains, and use of forceps necessitated. Now suppose the bag of water to be prematurely broken, it is not simply a momentary arrest of uterine contractions that we have, but the death of the fœtus by asphyxia is threatened.

Is there not still another danger to be noted? at the same time recognizing with Campbell: 1st. That the lengthening of the in-

tervals and the lessening of their duration and intensity by chloroform are especially observed in cases of exceptionally rapid and painful dilatation. 2d. That the labor, momentarily retarded, often resumes its normal rhythm of contractions and efforts which cause toward the end an accelerated movement, so as to compensate for the primitive retardation. From this we see that the cases of retarded labor observed by Pinard are in no wise contradictory to those of acceleration noted by Dumontpallier, since the retardation determined by chloroform may have taken place during the period of dilatation and the accelerated movement in the expulsory stage.

5th. There are women originally disposed to syncope, in whom the state of gestation, even the most normal, aggravates in a singular manner this disposition. Suppose that this fact be unknown to the accoucheur, is it not evident that chloroform would be dangerous? The disposition to syncope might be complicated with extreme susceptibility to chloroform, and this double idiosyncrasy might act simultaneously to compromise the essential functions from the very first inhalations.

6th. Beside the syncopal tendency must be mentioned, as so many dangers suspended over the head of the patient, all the diseases of the heart and respiratory tract which predispose to asphyxia, hypertrophy of the heart, valvular narrowings, tuberculosis, emphysema, pleuritic effusions, etc. It is true, Championnière does not believe that most of these affections contra-indicate the use of chloroform. But is this a reason why we should regard chloroform as innocuous in these diverse pathological states? We may brave a real peril ten, twenty times, but a day comes when by the neglect of a simple precaution or detail, we succumb. I might mention all the diseases of the nervous centers which give rise to passive hyperæmias, such as cerebral hæmorrhages, softening of the brain, etc. Also certain physiological or morbid states, such as a twin pregnancy, hydropsy of the amnion, and in general all the organopathic conditions which distend beyond measure the abdomen, crowding back the diaphragm and with it the heart and lungs, and causing syncope, asphyxia or visceral congestions.

7th. Finally, there is a danger almost as much to be feared

as most of those just mentioned, that which arises from a deficient obstetrical education. To administer the chloroform with measure, to keep, by means of suitable doses methodically given, the patient in a state of analgesia, which does not take away from her the exercise of her intellectual functions, and her consciousness, is very well. But if, by reason of faulty diagnosis, which is perhaps most commonly the case, the accoucheur overlooks a grave cause of distocia, deformed pelvis, presentation of the trunk, locking of the head by fault of rotation, etc., or any other circumstance requiring an operation, what will happen? The prolongation of the anæsthesia will bring on a situation as perilous for the mother as for the child, perilous because one waits instead of acting; perilous because the resistance of the obstacle annihilates the power of the obstetrical effort; perilous because this effort no longer produced, no longer exercises its disanæsthetic action upon the organism; perilous finally, because every labor which does not terminate, exhausts the forces of the mother and compromises the existence of the fœtus.

The author would not, therefore, entrust the administration of chloroform to internes and nurses in the absence of the physician, nor does he consider it advisable to allow midwives to give anæsthetics except under the advice and direction of the physician. Having reviewed the dangers and inconveniences of obstetrical anæsthesia, the author speaks of the advantages of this restricted anæsthesia.

1st. *Chloroform lessens the pains of uterine contraction.*—All the efforts of adversaries cannot prevail against this fact, slight in appearance, but undeniable, and great in practical consequences. They say it is not true anæsthesia. What matters it if the analgesia obtained is sufficient to make the patient bear patiently the pains so dreaded and so full of anguish? They say, also, that in this restricted anæsthesia the patient still suffers. True, but there are degrees in suffering. If, instead of suffering as ten I only suffer as one, should I not esteem as an immense benefit the agent that can reduce the pain in such a degree? The lessening of the pain by chloroform is not subject to an inflexible law; it may vary with individual susceptibilities, the doses being equal. The fact is beyond dispute.

2d. *Chloroform procures to the woman in labor a perfect calm during the interval of uterine contractions.*—M. Campbell describes the interval between contractions in this semi-anæsthesia as *a grand silence.* M. Lucas Championnère, Pinard and the author, have all observed that the patient remains perfectly calm during the interval.

3d. *Semi-anæsthesia helps the patient to pass easily through the painful period of dilatation.*—The first stage of this period is usually easily borne, the pains being short and slight, and the intervals long and painless. But in the second stage the pains are sharper and more frequent, and the intervals marked by increasing agitation; the woman suffers all the time, weeps, despairs, perceives no progress, and declares she can never stand it. Now, chloroform in small doses calms this agitation, dissipates fear and evil presentments, and allows the nervous system, shaken by the shocks of pain, time to recover its physiological equilibrium. M. Danyau is one of the first to make the possible application of anæsthesia to the period of dilatation. He says: "I think we may have recourse to simply attenuating doses of chloroform in cases of very slow and painful dilatation, even if we renounce it later, at the beginning of the expulsory stage, in general, much less painful, and moreover nearly always so valiantly supported by women."

4th. *Chloroform renders tolerable the great pains of the expulsory stage.*—While many women do support this stage well, yet, in all cases where the expulsory stage is long and painful, and especially in primiparæ, the author regards chloroform as a great boon, and if we did not have chloroform it should be discovered.

5th. *The certitude of being given chloroform frees the primiparæ from the terrors of labor. It gives to multiparæ, who have already experienced the benefits of anæsthesia a salutary confidence.*—True, most primiparæ do not dread parturition. They know they must suffer, but have a vague idea of the pains that await them, feeling, perhaps, that where the mother has passed the daughter may also pass. But there are others who regard it with terror, believing they shall never be able to live through it. Give such persons the assurance that chloroform will spare them

these pains, and their confidence is established and all their gloomy thoughts will vanish like a bad dream.

The multipara also, whether previously anæsthetized or not, on the promise of being given chloroform, will pass through the diverse stages of gestation full of confidence and security. It is well known what a happy influence the absence of inquietude and of all preoccupation has upon pregnancy.

6th. *Chloroform is one of the greatest aids in nervous or hysterical women, with exaggerated sensibility, whom the pains of childbirth throw into extreme agitation.*—The author gives the following case to illustrate the good effects of chloroform in a highly nervous woman: An extremely nervous young woman, pregnant for the third time, and at term, was taken during the period of dilatation with disordered movements which her husband, the nurse and myself could with the greatest difficulty repress. When left to herself, she sat up and lay down, turned and rolled about constantly, tossed about, threw her arms right and left, kicked, and in a word, gave herself up to the most violent gymnastics, ever crying, weeping, gesticulating. To put an end to these fantastic exercises he resorted to chloroform which produced complete quiet. Expulsion soon took place, during a relative calm, the uterine contraction being valiantly aided by the muscular efforts of the patient. He employed 80 grams of chloroform and there was neither sleep, nor period of excitation, nor abolition of consciousness.

7th. *Chloroform will also be very useful in all cases of delay or suspension of labor, whether from nervous exhaustion, local pains, neuralgic or otherwise, rigidity or spasmodic retraction of the neck, or from the effects of partial or irregular contractions of the womb.*—In addition to his own experience, the author refers to that of Dumontpallier, Cazeaux, Montgomery, Meigs, to support the truth of this statement.

It results from the preceding declarations that chloroform in obstetrics has numerous indications, and that the number of its advantages is far greater than the dangers. The more we advance in the discussion of this question, the more we enlarge the circle of its indications, and the better they are pointed out. It would be imprudent, almost unskillful, to use chloroform in all

cases without distinction. The contra-indication might emanate from not only certain abnormal conditions, but also from physiological circumstances, such as rapid and painless labor.

PATHOLOGY.

EXPERIMENTAL RESEARCHES ON SCROFULOUS AND TUBERCULOUS INFLAMMATION OF JOINTS. By M. Schüller. (*Centralblatt f. Chirurg.*, 1878, No. 43.

The starting point of the experiments was the well-known fact, that very slight injuries suffice to produce grave joint diseases in some individuals, while others will bear much more severe injuries without any such consequences. Healthy animals likewise, can sustain severe traumatic lesions of joints without more than mere temporary discomfort.

In order to produce a tuberculous tendency in animals, Schüller inoculated rabbits and dogs with tuberculous sputa, pieces of phthisical lungs or simple bacteria derived from tubercles and cultivated in nutrient solutions, according to the plan of Klebs. The fluids were injected into the lungs or inhaled by the animals from atomizers. In the course of some weeks, such animals become affected with pulmonary and even general miliary tuberculosis.

After the inoculation the animals were bruised so as to injure the knee-joint. Within some weeks the joints were examined, and in nearly all cases an inflammation was observed, consisting in a granular proliferation of the synovial membrane and a considerable swelling of the ends of the bones, which was noticeable during life as a tumefaction of the joint. In rare cases the joint suppurated.

Similar, although milder lesions were produced by direct injection of the infective fluids into the joint.

THERAPEUTICS.

RAPID RELIEF OF THE VIOLENCE OF ASTHMA BY THE HYPODERMIC USE OF MORPHIA.—By Dr. Henri Huchard. (*L'Union Médicale*, July 25 and 27, and October 3, 15, and 24, 1878.)

In several articles in the above mentioned journal, Dr. H. Huchard has strongly advocated the use of hypodermic injection of morphia in cases of asthma. Having found such marked relief in the spasmodic efforts at respiration, he argues that it exerts a special influence on the respiratory system. On this hypothesis, he pursued its application in other affections where the difficulty of respiration becomes a troublesome symptom, namely, in aortic affections, accompanied with cerebral anæmia, phthisis, and uræmia. After the publication of his first papers, Dr. H. received interesting cases from other physicians, in which its effects were equally happy.

Four well marked cases of relief of labored respiration, associated with interstitial nephritis, are carefully detailed.

In the concluding article, Dr. H. answers the following questions:

1. Can the hypodermic injection of morphia be substituted by the opium preparations, or by morphia introduced into the alimentary canal? Assuredly not.

2. Does not the frequent hypodermic injection of morphia produce serious inconvenience? Not when carefully performed. He begins with from 0.003 to 0.005 grams, increasing the dose to 0.01 or 0.015 grams at the most for each paroxysm.

3. Is it in virtue of its hypnotic action that morphia relieves the dyspnœa, or has it a direct action on the respiration? Mr. H. claims, however opinion may differ as to its physiological action, clinical experience establishes the fact that morphine facilitates respiration; *la morphine fait respirer.*

4. Does the morphine medication only relieve the symptom dyspnœa, without any influence on the duration of the disease which is the cause of the symptom? This question is referred to further observation, but the pain being relieved, the general system is necessarily benefited, and the disease thus probably modified.

FOR TOOTHACHE. (*The Doctor.*) Mr. Merson uses the following formula:

℞	Chloroform. pur.....	12
	Tr. aconiti (Fleming).....	12
	Tr. capsici.....	4
	Tr. pyrethri.....	2
	Ol. caryoph.....	2
	Gum. camph.....	2
	Misce.	

He abolishes the pain of extraction by first drying the gum and tooth, and then applying four or five drops of the above on a little cotton. Then, having previously *warmed the forceps*, extract without delay. For toothache, a pellet of wool soaked in the above may be introduced into the cavity, and often gives instant relief.

SALICYLIC ACID AS AN ANTAPHRODISIAC. (*The Doctor*, Oct. 1, '78.)

Dr. Jewett and others have observed that salicylic acid appears to possess great power as an antaphrodisiac. Some patients who have taken it, are reported to have lost sexual power for months. If these statements prove correct, the drug may be made very useful. Gram doses of sodic salicylate five times daily are said to have abolished the power for three months.

TREATMENT OF NOCTURNAL ENURESIS.—(*The Doctor.*)

Kelp treats this affection by weak doses of nitrate of strychnia injected subcutaneously in the region of the sacrum. One or two injections, the second some days after the first, are usually sufficient.

ENORMOUS CONSUMPTION OF QUININE IN THE RUSSIAN ARMY.—The Russian military hospitals have consumed, during 1877, six thousand kilogrammes of the sulphate and three thousand kilogrammes of the chloro-hydrate of quinine. Enormous as this consumption is, it will be exceeded by that of the current year.—*Lyon Méd.*

Items.

ON THURSDAY, DEC. 19TH, Professor Gunn, after a severe and protracted illness, made his first appearance before the class at Rush Medical College. The Professor was too much prostrated to make any attempt at lecturing, and therefore contented himself with greeting his friends.

In honor of the event, the class had determined upon a welcome with floral decorations. The upper lecture room, where the professor is accustomed to deliver his valuable surgical lectures, was most tastefully decorated with plants, flowers and evergreens. The blackboard, where usually can be found the announcements respecting "material for class," etc., was covered with white cloth, and trimmed with evergreens and holly. In the centre was the word "Congratulamus" in large evergreen letters. Above the blackboard the wall was also tastefully decorated with evergreens and holly. In the centre—in its accustomed place—was the bust of Dr. Gunn's predecessor, Professor Brainard. Immediately at the foot of the middle aisle, upon the rail, was placed an elegant stand of flowers, the base of which was about six feet in circumference—a solid mass of camelias, tuberoses and carnations. Rising from this was a large basket of flowers pyramidal in shape, surmounted by a lilly, with camelias and tuberoses thickly scattered around it. A small wire stem, tastefully decorated, and rising from the main basket, supported the monogram M. G. At the foot of each of the two other aisles was placed a large basket of flowers, somewhat similar to the first, but not so large. Two baskets, of intermediate size, were placed upon the shelves or tables at the sides of the arena. Plants were thickly scattered about, and the place had an appear-

ance so very unusual that probably none of the professor's clinical patients who visit him there on Saturday afternoons, would have recognized it as the arena where epithelioma, necrosed bone, etc., had so often yielded to the touch of the operator.

Mr. Miller, the class president, welcomed the professor in a few well chosen words, expressing the delight of the members of the class in receiving their honored professor, after his narrow escape from the "king of terrors," and presented to Dr. Gunn the main stand of flowers.

The professor's strength would not permit an extended reply, and after expressing his thanks to the class in a very appropriate manner, he withdrew.

Three cheers were then proposed, and the proposition was most heartily responded to.

The class then dispersed, to meet again at 4 o'clock to listen to Prof. Parkes, who has so ably filled the chair of surgery during the absence of its regular occupant. L. C. W.

JUSTICE TO DR. SIMS.—Several medical periodicals in this country have lately published paragraphs containing statements similar to the following, which we find in the *Detroit Lancet*, of Nov., 1878:

"A correspondent of the CHICAGO MEDICAL JOURNAL states that all the patients Dr. J. Marion Sims operated on while in Vienna, died within ten days of peritonitis."

It was the *Boston Medical and Surgical Journal*, we believe, that first gave prominence to this item, and that subsequently explained the manner in which the error was committed, by which an unnecessary reflection was cast upon Prof. Sims' skill as an operator.

Our Vienna correspondent, writing under date of July 15, 1878 (see Sept. No. of CHICAGO MEDICAL JOURNAL AND EXAMINER, p. 295) uses the following language:

"Among these (operations) he (Dr. Sims) did three for the removal of cancerous portions of the womb by a method called by the Germans the "Trichterförmige Excision," which consists in cutting away with the scissors, a funnel-shaped portion of the cervix uteri, extending, when necessary for the removal of the

diseased tissue, into the body of the womb itself. In fact, as done by Dr. Carl Braun, the procedure consists in removing the whole lower portion of the muscular tissue of the uterus, close upon the edge of the peritoneum. Dr. Sims' patients operated upon here, all died of peritonitis within ten days of the operation."

In other words, the three operations, all done for cancerous disease and all involving the tremendous risks of the grave Trichterförmige Excision, terminated fatally.

The great difference between this statement and the isolated sentence which is going the rounds of the medical press, must be apparent to all. Justice to our eminent countryman, now abroad, should lead all our contemporaries who have made the blunder to retract their statements.

MR. SPENCER WELLS.—We have recently published a series of papers detailing results in ovariotomy by British and foreign surgeons, such as may well make all Englishmen glad and proud.

If ovariotomy is now, as the results of Spencer Wells, Keith, Nussbaum and Knowsley Thornton show it to be, an operation which is not so hopeless and desperate as to seem unjustifiable even in the face of surely impending death from ovarian disease; if it is now an operation which gives but two deaths in forty-nine cases (and these two cases specially and palpably unfavorable for operation), that grand achievement of science and magnificent boon to humanity is due mainly to the ceaseless exertions of a British surgeon, Mr. Spencer Wells. His name, illustrated by such associations and bound up by undying recollection with the most splendid progress in modern surgery, needs no other decoration. But how strange a commentary on the principles on which the scanty honors of the state are distributed among members of our profession, that it should stand thus undignified in the sense in which alone sovereigns and states can dignify the princes of science or recognize their enduring services to mankind. Had Mr. Wells improved some engine of destruction, he might long since have been gazetted K.C.B. Had he amassed great wealth by selfish means or for selfish ends, he might have been ennobled; in the legal profession he would long since have been on the woolsack, or in the church a spiritual

lord. Had his services, of however ordinary a kind, been to the court even in his own noble profession, he could hardly have been long left undistinguished. But, as it is, the name which is throughout the world one of the chief glories of England, as a benefactor to humanity by a specially valuable and touching addition to our means of saving much-loved lives, is also a standing reproach to the indifference with which the highest kind of achievement in life-saving is regarded in governing circles and by the advisers of the crown in the distribution of the honors of which it is the source.—*British Medical Journal.*

IT is generally known to the medical profession and those interested in bibliography that Dr. John S. Billings, Surg., U. S. A., in charge of the National Medical Library, at Washington, is now ready to print his great "National Catalogue of Medical Literature," as soon as Congress grants an appropriation for the purpose. This indexes under subjects, and by authors, books, pamphlets and original papers in nearly all the medical perodicals of the world; including over 400,000 subject entries, and making ten volumes royal 8vo of 1,000 pages each. This will be of the greatest value to physicians the world over, as it enables them to find analogues for peculiar and difficult cases, and thus often to save lives. In continuation of this work, it is now proposed to publish monthly, under the editorship of Dr. Billings and of his assistant, Dr. Robert Fletcher, M. R. C. S., a current medical bibliography under the title of the *Index Medicus*. It will be issued by F. Leypoldt, the bibliographic publisher, 37 Park Row, New York, at $3 per year, and will enter all medical books and index the leading medical journals and transactions in English and other languages. A full list of the latter, numbering over 600, will form a part of the specimen number of the *Index*, soon to be issued.

SUITS for malpractice are so common as to constitute an epidemic in the State of New York.—*Buffalo Med. and Surg. Jour.*

THE science of the physician is above the assertions of the patient.—*Ricord.*

ANNOUNCEMENTS FOR THE MONTH.

SOCIETY MEETINGS.

Chicago Medical Society—Mondays, Jan. 13 and 27.
West Chicago Medical Society—Mondays, Jan. 6 and 20.

CLINICS.

MONDAY.

Eye and Ear Infirmary—2 p. m., Ophthalmological, by Prof. Holmes; 3 p. m., Otological, by Prof. Jones.
Mercy Hospital—1:30 p. m., Surgical, by Prof. Andrews.
Rush Medical College—2 p. m., Dermatological and Venereal, by Dr. Hyde; 3 p. m., Medical, by Dr. Bridge.
Woman's Medical College—2 p. m., Dermatological, by Dr. Maynard.

TUESDAY.

Cook County Hospital—2 to 4 p. m., Medical and Surgical Clinics.
Mercy Hospital—1:30 p. m., Medical, by Prof. Hollister.

WEDNESDAY.

Chicago Medical College—1:30 p. m., Eye and Ear, by Prof. Jones.
Eye and Ear Infirmary—2 p. m., Ophthalmological, by Dr. Hotz.

THURSDAY.

Chicago Medical College—1:30 p. m., Medical, by Prof. Quine.
Rush Medical College—3 p. m., Diseases of the Nervous System, by Prof. Lyman; 4 p. m., Diseases of the Chest, by Prof. Ross.

FRIDAY.

Cook County Hospital—2 to 4 p. m., Medical and Surgical Clinics.
Mercy Hospital—1:30 p. m., Medical, by Prof. Davis.

SATURDAY.

Rush Medical College—2 p. m., Surgical, by Prof. Gunn.
Chicago Medical College—2 p. m., Surgical, by Prof. Isham; 3 p. m., Neurological, by Prof. Jewell.
Woman's Medical College—11 a. m., Ophthalmological, by Dr. Montgomery.

Daily Clinics, from 2 to 4 p. m., at the Central Free Dispensary, and at the South Side Dispensary.